HEALTH, EXPERTS
AND THE POLITICS OF KNOWLEDGE:
BRITAIN AND SWEDEN 1900-40

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ABSTRACT

HEALTH, EXPERTS AND THE POLITICS OF KNOWLEDGE:
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Early twentieth-century public health campaigns provide a useful means of examining the role that scientific knowledge has played in urban governance. By invoking the authority of science, public health experts and executives could claim that the way in which they analyzed and organized the life of the city was above class antagonisms, gender conflicts, ethnic tensions and the politics of age relations, serving the best interest of the whole community. This study, which compares infant welfare and anti-tuberculosis campaigns in the second cities of Britain and Sweden, Birmingham and Gothenburg, shows how health authorities used 'apolitical' scientific knowledge to regulate their city and to advance political aims.

The study examines the role which infant welfare campaigns played in regulating urban family life and family relations. While the Birmingham campaign promoted full-time motherhood, in Gothenburg, where many households were dependent on women's wages and where industries were concerned to employ female labour, the authorities argued that the well-being of infants could be secured by helping poor mothers reconcile paid work with motherhood. Both these campaigns, though reflecting local economic arrangements and social structures, were anchored in 'universal' scientific knowledge. By comparing the anti-tuberculosis campaigns in Birmingham and Gothenburg, this study shows that these campaigns served to justify the central tenets of the municipal housing policies. The way in which tuberculosis was defined legitimated intervention in the homes and intervention or non-intervention in the housing market.

The health campaigns enhanced the interests of medical doctors. In Gothenburg, where the majority of doctors worked in the public sector, public health problems were often defined as medical matters which were to be resolved by professionals. The Birmingham authorities, reluctant to damage the interests of independent practitioners, confined their activities to preventive medicine. Finally, the study examines how middle-class women and working-class women and men challenged the authorities' views.
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".. the ideas of economists and political philosophers, both when they are right and when they are wrong, are more powerful than is commonly understood. Indeed the world is ruled by little else."

"I am sure that the power of vested interests is vastly exaggerated compared with the gradual encroachment of ideas."


John Maynard Keynes has not been alone in thinking that powerful ideas import the dynamic into policymaking. Many twentieth-century theorists have argued or simply assumed that practical policies follow ideas which are developed in scientific communities or academic establishments. However, this view on the relationship between scientific ideas and public policies has also been strongly criticized. Underlying it, the critics argue, is the untenable assumption that governments are little more than passive consumers of ideas that economists and other specialists offer. The critics point out that the ways in which 'Keynesian' policies were introduced in different countries in the 1930s and 1940s alone show that the relations between theory and practice or between scientific ideas and public policies are far more complicated than Keynes suggested. Furthermore, many late twentieth-century writers would castigate Keynes for separating ideas and vested interests and for ignoring the constant interaction between them. In the burgeoning literature on the history and philosophy of science over the past three decades, there has been a growing acceptance of the view that scientific knowledge and ideas are always produced "in and through social processes" not in isolation from them.


However, Keynes' failure to unravel the complex relations between science and public policy did not render his brief excursion into the sociology of knowledge unimportant. The fact that the discourse about powerful ideas has often been lacking in analytical rigour has not hindered it from playing a critical role in policymaking. In the area of urban public health, which is the primary focus of this study, the importance of this type of discourse was unmistakable in the early twentieth century. Public health authorities, both experts and executives, sought systematically to convey the impression that scientific discoveries and theories, uncontaminated by vested interests, were the major driving force behind environmental improvements and health care reforms. Powerful moves in health policy came as a result of important advances in medicine and science. Once scientists had revealed that the micro-organisms which caused cholera and typhoid were conveyed by contaminated water, health authorities did everything in their power to provide townspeople with safe and pure water. As a response to the discovery of the causal agent of tuberculosis, authorities launched extensive campaigns against the disease, protecting the healthy and providing the sick with treatment. Furthermore, they were waiting impatiently for a major breakthrough in cancer research so that they could take a determined action to conquer this disease. All the signs were that science would win also this war, eventually. As the Medical Officer of Health for Birmingham, Dr. John Robertson, put it in 1922, "(s)ome encouragement may be taken from the fact that throughout the world more money is being spent on investigation into the causation of this disease than has ever been expended on research in connection with any other single disease." What was needed was a great breakthrough.

Public health authorities did not argue that a generous cheque to cancer researchers would be the answer to urban health problems. What they wanted to win by sheltering behind the authority of science was the public's support and sanction to policies they themselves pursued. Firstly, they sought to convince the institutions, and state; Ludmilla Jordanova, 'The social construction of medical knowledge', Social History of Medicine 8 (1995), 361-81, the quote 363. Some of these writers (see in particular Furner and Supple) do not want to deny "the possibility of a significant degree of autonomy in the evolution of ideas."

Public health authorities' and 'health authorities' will be used throughout this thesis to mean both experts and executives who participated in constructing public health policies. At the local level, the responsibility for health policy was shared among two executive bodies, the Public Health Committee and the City Council, and appointed health officials who worked for the Public Health Department and for municipal hospitals. At the national level, the most important role was played by central government departments such as the Local Government Board and the Ministry of Health (from 1919) in Britain and Medicinalstyrelsen (The National Board of Health) in Sweden.


7 For discussion about the legitimizing authority of science, Christopher Hamlin, A Science of Impurity: Water Analysis in Nineteenth Century Britain (Bristol 1990), 1-13, 299-305; David S. Barnes, The Making of a Social
politically influential knowledge

public that, within their financial limitations, they dealt with health and environmental problems as efficiently as possible, going as far as modern science equipped them to go. Secondly, and perhaps more importantly, they wanted to assure the public that health policy was not political. Many problems which fell within the compass of public health - infectious tubercular patients in overcrowded homes, malnourished and overworked mothers with large families, and infants who died since their parents lacked both the knowledge and means to look after them properly - brought authorities face to face with highly controversial issues. They could not but realize that urban health problems were not only about germs and bad habits but also about poverty, low wages and high rents, about defective housing and unhealthy workplaces, about women's inequality in the labour market and in the family, and about society's insensitivity to 'children's rights'. Yet a scientific approach - systematic investigations, impersonal statistics, bare facts and balanced reports - permitted public health authorities to discuss these types of contentious issues, to offer opinions and answers, without having to acknowledge that they themselves were deeply involved in these political and social conflicts. By invoking the authority of science they could claim that the way in which they analyzed and organized the life of the city was above class antagonisms, gender conflicts, ethnic tensions and the politics of age relations, serving the best interest of the whole community.

--- SCIENTIFIC KNOWLEDGE AND URBAN POLITICS ---

This study explores the 'political' and cultural history of public health, examining in particular how health authorities, wittingly and unwittingly, used 'value-free' scientific knowledge to advance economic, political and social interests in early twentieth-century industrial cities. The scientific knowledge in which public health programmes in Britain and Sweden were anchored was partly 'produced' by public health officials


8 For the 'neutralization' of politics, see Theodore M. Porter, Trust in Numbers: The Pursuit of Objectivity in Science and Public Life (Princeton 1995); Dominique Pestre, 'Science, political power, and the state', in John Krige and Dominique Pestre (eds), Science in the Twentieth Century (Amsterdam 1997), 61-75; Scott, Gender, 113-38; Proctor, Cancer Wars; Karin Johannisson, 'Folkhälso: det svenska projektet från 1900 till 2:a världskriget', Lychnan (1991), 139-95. See also, for example, the connections between science, statistics and eugenics, MacKenzie, Statistics in Britain; Greta Jones, Social Hygiene in Twentieth Century Britain (London 1986); Nils Roll-Hansen, 'Eugenics before World War II: the case of Norway', History and Philosophy of the Life Sciences 2 (1980), 269-98.

9 It is obvious that early twentieth-century health authorities were aware of class and gender tensions and that they made a conscious effort to assure the public of their 'neutral' position in these conflicts. Whether authorities conceived of age and ethnic relations as 'political' issues is another matter altogether. Children, elderly people and ethnic minorities did not have political movements such as socialism and feminism to represent their interests and to disclose the political nature of age and ethnic relations. For discussion about the ideological omission of children and elderly people's viewpoints in policy-making and research, see Harry Hendrick, Children, Childhood and English Society, 1830-1990 (Cambridge 1997), 4-7, 36-40; Margot Jefferys and Pat Thane, 'Introduction: an ageing society and ageing people' and John Macnicol and Andrew Blakie, 'The politics of retirement, 1908-1948', in Margot Jefferys (ed.), Growing Old in the Twentieth Century (London 1991), 1-18, 21-42.
themselves. By using sanctioned scientific methods, and especially statistical techniques, health officials produced 'value-free' knowledge, for example, about the incidence of diseases among different sections of the population and about the links between particular ways of life and the exposure to disease and death. Alongside this type of statistical knowledge, they made use of the latest findings of medicine and the natural and social sciences to analyze urban health problems and to respond to them.\footnote{In this chapter, a distinction is made between the production of knowledge and its deployment in order to clarify the argument. This distinction is artificial; producing and using knowledge cannot be separated from each other. For further discussion, see the section 'Constructed knowledge, engineered ignorance'.}

How did public health programmes, and the statistical and scientific knowledge on which they were based, further political and economic interests and reinforce cultural and moral norms? Recent debates about socio-cultural dimensions of medicine and health care have provided useful insights into this theme. Particularly important is the recognition that basic social implications of capitalist economic arrangements, the family system, and the nation state have always shaped our knowledge about health and illness irrespective of whether this knowledge has been primarily produced by scientists in research institutions or health officials in Public Health Departments. Hence the identification of collective well-being with the market economy and family system has been implicit in basically all definitions of public health problems and in responses to them. This in turn has meant that the tools of public health medicine, while sharp for some health problems, have usually been dull for problems which derive from, for example, economic insecurity, gender inequality or unreasonable family obligations.\footnote{See, for example, Alan Sears, "To teach them how to live": the politics of public health from tuberculosis to AIDS,' \textit{Journal of Historical Sociology} 5 (1992), 61-83; Proctor, \textit{Cancer Wars}; Gerry Kears, 'Tuberculosis and the medicalisation of British Society, 1880-1920', in John Woodward and Robert Jütte (eds), \textit{Coping with Sickness: Historical Aspects of Health Care in a European Perspective} (Sheffield 1995), 147-70; Howard Waitzkin, 'A critical theory of medical discourse: ideology, social control, and the processing of social context in medical encounters', \textit{Journal of Health and Social Behaviour} 30 (1989), 220-39; Barbara Harrison, 'Women and health', in June Purvis (ed.), \textit{Women's History: Britain, 1850-1945: An Introduction} (London 1995), 157-92. For an overview of research on socio-cultural dimensions of medicine and health care, see Deborah Lupton, \textit{Medicine as Culture: Illness, Disease and the Body in Western Societies} (London 1995 printing).} By building on these insights, this study aims to shed light on how scientific knowledge about health and illness was used to organize and regulate urban societies. In order words, the attempt is to unite the analysis of urban governance with the enhanced understanding of the authority of science in society.

On first consideration, the achievements and objectives of municipal health campaigns seem very straightforward. The aim was to promote health. Annual reports which municipal health authorities published gave detailed accounts of declining mortality and morbidity rates and suggested how things could be further improved. However, health authorities had also other important functions which inevitably influenced the way in which they understood health problems and responded to them. These other roles were rarely discussed partly because health authorities themselves took them for granted and partly because they preferred them unstated and undiscussed.\footnote{For the different roles of local states, see in particular Mike Savage and Alan Warde, \textit{Urban Sociology, Capitalism and Modernity} (London 1993), 147-87; R. J. Morris, The state, the elite and the market: the 'visible
vital role in regulating the local economy. As economic growth was believed to be in everyone's interests, public health authorities were likely to accommodate the demands of the local business community without analyzing the benefits and costs of this line of action. The efficient working of the local economy could be buttressed, for example, by securing amenable planning decisions or by developing basic urban infrastructure which was vital for the manufacturing and distribution of goods. Furthermore, housing and health authorities could refrain from intervening in the housing market or medical market in ways which would have seriously damaged the private sector. On the other hand, health authorities could also restrict the operation of local industries and trades by imposing regulations which were aimed at curtailing pollution, at improving housing standards or at protecting children and women employed in factories.

Secondly, the role of municipal departments was considerable in maintaining social order and discipline in cities. The local police force, with which this function was usually associated, was clearly not the only municipal department that was concerned with preserving social order. Public health authorities could ease tensions and confine conflicts in urban society by repairing some of the damage - ill-health and other forms of social need - which the economic life inevitably left behind it. Furthermore, public health policy could seek to stabilize urban society by highlighting its bedrock principles and values and in particular by maintaining the work ethic and buttressing the family institution. Children without parents, mothers without husbands and men without jobs could be singled out for attention as problem groups, whose conduct had to be regulated in the name of health. When public health authorities sought to protect the community from infectious, dangerous diseases, they were often allowed to take the discriminatory approach a step further and to apply coercive powers in order to isolate the sick from the rest of society.\(^\text{13}\)

Thirdly, municipal authorities were important intermediaries in the formation of collective identity. On the one hand, they could encourage associational life based around schools and workplaces, churches and chapels, and co-operatives and clubs. These collectivities had an important role in 'modern' urban society, since they provided "a basis for orderly belonging," diminishing apathy and disaffection. On the other hand, organized groups could also cause problems; their endless claims for rights and resources were difficult to fulfil and their protests threatened public order. Consequently, municipal authorities might prefer "to disorganise such people, to fragment and individualize the social body."

\(^\text{13}\) Many writers have discussed the ways in which health and welfare policies served to maintain social order but only few of them have used an urban focus to analyse this question. Most writers have concentrated either on state strategies or on encounters between clients and the members of "helping" professions. See, for example, David Vincent, *Poor Citizens: The State and the Poor in Twentieth Century* (London 1991), in particular 39-45, 141-7; Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939* (London 1980); Susan Pedersen, *Family, Dependence and the Origins of the Welfare State: Britain and France 1914-1945* (Cambridge 1995 printing); Waitzkin, 'A critical theory of medical discourse'; Heta Hityry *The Limits of Medical Paternalism* (London 1991); John Kleinig, *Paternalism* (Manchester 1983).

\(^\text{14}\) Savage and Warde, *Urban Sociology*, 150-1.
The impact of these political aims and demands on health policy is explored by examining public health programmes in the second cities of England and Sweden, Birmingham and Gothenburg, and by placing these case studies in a wider Northern European context. The British and Swedish public health experts were part of one public health community, enjoying close links, attending the same international conferences and contributing to the same journals. They clearly spoke the same 'language' and had access to the same body of medical knowledge. In both these countries, public health authorities claimed firm scientific grounds for their programmes. In fact they saw themselves as the leading edge of a new era of health policy which would promote well-being and prosperity by providing scientific solutions to social and health problems. In a very conspicuous way they often stood aside, leaving research findings and statistical analyses to inform policy and to justify decisions. The problems that public health authorities dealt with in industrial cities in Britain and Sweden were also very similar. On the basis of these factors one could assume that the public health policies pursued by the Birmingham and Gothenburg authorities would have been relatively close to each other. Yet they were often strikingly different and these differences were not necessarily related to the severity of the problem.

By comparing public health policies in Birmingham and Gothenburg and by analysing differences between them, this study illustrates clearly how different, equally logical, conclusions could be drawn from the same medical facts and findings. In both towns, health policies were anchored in 'universal' scientific knowledge and at the same time they reflected closely local economic arrangements, social structures and moral concepts. In other words, in promoting health, authorities could also encourage and regulate the local economy, to maintain social order and to attach town-dwellers to acceptable collectivities. Respective weightings of these different aims varied considerably from case to case, and it is important to bear in mind that health promotion, in the narrow sense of the word, was not always the main priority. Furthermore, this study sheds light on the very process whereby local political and social concerns became embedded in 'apolitical', 'value-free' health policies and on the role which scientific knowledge played in this process. Health authorities shaped scientific knowledge about health and illness in a way which enabled them to reconcile different aims and to mediate conflicts between social classes and between different gender, ethnic and age groups. Reconciling different, often conflicting, aims was a continuous process. For example, there seemed to be unsolvable divergences between the supporting of the family institution and the facilitating of the free market mechanisms. Similarly, there were clearly some tensions between the measures which aimed at improving the well-being of women and the measures which supported the male bread-winner family model. Having alleviated one set of problems, municipal authorities often realized that they had made another set worse. However, no matter how unstable and fragmented health policies were, when placed on firm 'scientific' foundation they appeared relatively coherent and consistent. Irrespective of the fact that they clearly reinforced existing relationships of power and structures of inequality, they could be defended as impartial and value-free.15

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15 Savage and Warde, *Urban Sociology*, 147-87; Ann Oakley, *Man and Wife: Richard and Kay Titmuss: My Parents' Early Years* (London 1997). 6. Jose Harris has argued that the belief in natural unity of social and market concerns began to fragment around the turn of the century. For example, many theorists became "increasingly aware
This comparative study brings two points into sharp relief. Firstly, it shows that urban governments were clearly not such passive consumers of scientific knowledge as they themselves or theorists like Keynes suggested. On the contrary, public health officials working in large cities, together with the leading executives on municipal Health Committees and medical civil servants in central government, played an active role in shaping knowledge. Indeed in constructing public health policies they exerted considerable influence on what was taken as scientific knowledge in society. They themselves ‘produced’ scientific knowledge and, more importantly, when they ‘consumed’ knowledge which was produced outside Public Health Departments they used it selectively, reshaping and reconstructing it to suit broader political purposes.

Secondly, this study shows clearly the large extent to which political decisions were (and are) justified by appeals to the authority of ‘value-free’ science. Despite the enormous power which scientific knowledge has had as a legitimizing rhetoric in municipal policy-making, the role of experts and scientific knowledge in regulating the city has not been systematically studied by urban historians. Moreover, urban historians have often focused too closely on class to recognize interest groups which are defined along gender or generational lines. By concentrating on scientific knowledge about health and illness, it is possible to examine how municipal authorities dealt not only with class antagonism but also with other urban conflicts. This approach also opens an opportunity to discuss how different groups contested health authorities’ views and how they used scientific knowledge to articulate their demands.

Finally, this study does not argue that public health authorities abused science to advance political aims or suggest that they could have used science in a better, apolitical way. An approach of this type would imply that there were value-free scientific ideas and theories which some right-minded, enlightened health authorities could have used to the ‘real’ benefit of the whole community. This certainly was not the case: all scientific theories and ideas as well as their applications were affected by political and social concerns. By looking at the policies that the Birmingham and Gothenburg health authorities pursued, this study examines processes whereby power structures were legitimated and challenged in urban societies and the role which scientific...
knowledge and 'scientific' public health policy played in these processes. Making moral judgements about what individual health officials or executives did or did not do is of no interest here. However, before developing the research questions further, it is important to discuss in more detail why medical power grew in municipal policy-making and why science and medicine became so important as a source of authority. It is argued here that both public health experts and executives actively built up the prestige of science in the late nineteenth and early twentieth centuries. The different reasons why they promoted a new scientific policymaking culture, and the negotiations and conflicts through which they managed to build up their own status and that of science will be discussed in the next two sections.

--- EXPERTS ---

As in other professional spheres, appointed health officials and in particular public health doctors looked to science both to certify the fairness and efficiency of the policies they pursued and to improve their own professional status. In the late nineteenth and early twentieth centuries, public health doctors in all Northern European countries aspired to become experts on whom society would rely for the cultural authority over a wide range of issues and whom society would reward with economic security and high professional standing. Science which was rapidly rising "to a privileged status in the hierarchy of persuasive belief" was the base on which they largely built their professional campaigns. In other words, the pursuit of scientific 'objectivity' and 'neutrality' in the construction of health policies became an essential part of public health doctors' professional project. Why did 'objective' scientific knowledge come to play so important a role in public health doctors' campaign for a higher professional status? What might public health doctors have expected to gain by convincing health executives and the public that they were able to view health and social problems objectively and impartially? Why did they fear the intrusion of values into their work? There are, depending on the country, different answers to these questions, but Theodore M. Porter's


conclusion that "(o)objectivity lends authority to officials who have very little of their own" can be applied, with modification, to public health experts in Britain and in the Nordic countries.22

The status and power of the whole of the medical profession rose significantly in the late nineteenth and early twentieth centuries. Studies concerned with the professionalization of medical doctors have shown that the social basis of their authority varied considerably from country to country, but these studies have also revealed some close parallels. What was common to all medical doctors across national borders was that the success of their professional project did not depend on how effective and successful their therapeutic or preventive measures were. The assumption that doctors' growing authority was based on their capacity to transform important scientific discoveries into effective practical procedures that cured illnesses and alleviated suffering is convenient for many purposes, and it certainly is convenient for doctors themselves, but there is hardly any evidence to support this hypothesis. Efficiency, as many writers have shown, was not an important criterion of occupational status in the late nineteenth and early twentieth centuries any more than it seems to be in the late twentieth century. Neurologists are highly respected despite the fact that they are only rarely able to cure serious neurological conditions, whereas venereologists, whose therapeutic measures are usually successful, are not.23

Thus, the authority of the medical profession was not based on their capacity to utilize the content of science. Rather, it was based on their ability, firstly, to build up the prestige of science and to turn it to their advantage and, secondly, to combine the status they got from this new source with the traditional ways of legitimizing their aspirations. In Britain, because of different traditions, the development of the interconnection between science and professional authority followed somewhat different lines from that in the Nordic countries and Germany. The differences are relevant to this study since they shed light on public health doctors' standing in these societies, and in particular on their power and prestige in relation to other segments of the medical profession and to the state bureaucracy. These aspects are important in explaining why public health doctors in both Britain and other Northern European countries, despite different circumstances, were determined to ground their expertise on 'objective', scientific knowledge.

New hierarchy in medicine - new order in industrial cities

Although all British doctors across the wide spectrum of medical careers saw science as a vehicle for bolstering their authority, the profession, as Christopher Lawrence shows, was "extremely variegated ... in its

22 Porter, Trust in Numbers, 8.

definition, evaluation and use of science." The men at the top of the profession were very selective in invoking the authority of science, since they considered science both an opportunity and a threat. In the late nineteenth century, the professional authority of the British medical élite was still largely founded on their classical education, on their appointments at voluntary hospitals and medical schools and on their wealthy clientele who chose their doctors on the basis of class background, not of medical skills and scientific merit. While these pre-eminent physicians often emphasized the scientific basis of medicine, many of them were strongly opposed to reforms which threatened to reduce clinical medicine to a body of technical, scientific knowledge which could be mastered by anyone who had medical training. It was in their interest to draw a distinction between 'ordinary' scientific knowledge and the knowledge which was needed in good clinical practice. The knowledge which the great clinicians possessed, they argued, was 'incommunicable' and private, since it came only with long experience and the bearing of a gentleman, whereas scientific, 'objective' knowledge was 'communicable', public and, at least in theory, available to everyone.

Despite the determined rearguard action fought by some élite members of the medical profession, scientific research methods and laboratory-based techniques steadily gained ground in the British medical world, from medical research to public health medicine and finally to bedside medicine. The great appeal of scientific techniques for public health doctors is not surprising. In late nineteenth-century and early twentieth-century industrial cities, public health officials - not hospital consultants or general practitioners - were in the front line of mediating class conflict and other social tensions and of regulating those aspects of urban life which appeared to threaten public health and the prevailing social order. Steve Sturdy, who has looked at the growing involvement of laboratory science in both clinical and public health medicine in Sheffield, has shown that scientific knowledge and techniques contributed to the development of new managerial and administrative responses to urban problems in the late nineteenth and early twentieth centuries. In the new administrative culture, which reflected the political shift from Tory paternalism to more Liberal views, experts surveyed society, identified appropriate sites of intervention and sought to intervene at these sites with maximum efficiency and minimum cost and criticism. Public health science which located problems and suggested 'value-free' responses to them became indispensable to the running of large industrial cities.
Another reason why many public health doctors were at the forefront of the introduction of scientific techniques was that they saw in this approach a chance of improving their own professional standing. Thus, if the élite doctors who opposed scientific techniques were not completely disinterested, nor were the public health doctors who advocated these reforms. Both groups had their own interest at heart. The push for a scientific approach in both public health medicine and clinical medicine came mainly from aspiring young doctors who were often soundly read in basic sciences rather than classics and whose class background was not likely to smooth their way to the positions of power. For them, the best chance of accumulating professional authority was to build up the prestige of science and of scientifically trained experts.

This challenge to the old order had partial success both in the field of clinical medicine and in that of public health. Among public health officials, full-time medical officers of health in particular succeeded in improving the economic and social status of their office by introducing stricter scientific standards for their work. Yet the changes which the scientific approach brought about within the medical profession and in society in general were by no means radical. Once the medical élite acknowledged that scientific techniques had come to stay and that further resistance would be futile, they concentrated on controlling the direction of the change. As a result, the new hierarchy of British medicine which took shape in the early twentieth century largely reflected and reinforced the same class divisions as the old one. While the social and economic position of leading health officials improved, they were still far from the top of the profession.

**Boundary settlements between the state and experts**

In the Nordic countries and Germany the adoption of new scientific knowledge and techniques in public health medicine was stimulated by very similar factors to those in Britain. Public health doctors working in urban areas were interested in reforming their work, since new scientific techniques provided them with means of 'knowing' the population and efficient methods of managing it. Moreover, many public health doctors hoped that by forging a new scientific identity for their speciality they could strengthen their professional...

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29 Sturdy, 'The political economy'; Porter, 'Stratification and its discontents'. For the ways in which élites have regulated the direction and pace of social and economic change, see for example, Richard Rodger, 'Managing the market - regulating the city: urban control in the nineteenth-century United Kingdom', in Diederiks, Hohenberg and Wagenaar (eds), *Economic Policy in Europe*, 200-19; idem, 'L'interventionnisme municipal en Écosse 1860-1914: civisme local, préoccupations sociales et intérêts des possédants', *Genèses* 10 (1993), 6-30.

status. On the other hand, the locus of this status competition was one factor which clearly distinguished the development of new 'scientific' public health medicine in Britain and in other Northern European countries. In Britain, leading public health doctors, together with university professors and aspiring general practitioners, allied themselves to the development of science to strengthen their status in society in general and in relation to the old medical élite which consisted almost exclusively of upper- and upper-middle-class doctors. In contrast, in Germany and especially in the Nordic countries, the medical profession invoked the authority of science to enhance their prestige and power in relation to the state bureaucracy. These distinctive characteristics are largely traceable to the extent and nature of state intervention in the medical market in these countries.³¹

The development of the British medical profession shows that state intervention in health care and a high level of professional autonomy and control on the part of medical doctors were not necessarily antithetical to each other. The 1858 Medical Act had set the seal on the partnership between the state and orthodox medicine, giving registered medical doctors official recognition and distinguishing them from 'unqualified' practitioners such as homeopaths, bone-setters and medical botanists. In the late nineteenth and early twentieth centuries, the state further supported medical dominance in the arena of health and disease by closing off many avenues of advance for other health workers such as midwives, nurses, radiographers and physiotherapists.³² At the same time, the medical profession was largely allowed to set its own standards and rules, and the role of the state in regulating and expanding the market for medical services was relatively limited. Local authorities offered medical practitioners full-time careers and part-time posts as medical officers of health, poor law medical officers, factory inspectors and, in the early twentieth century, as school medical officers, but these office-holders were in a minority in the medical profession. The National Insurance Act of 1911 increased state involvement in the medical market substantially, but medical doctors' control over their own work was ensured by giving them considerable scope to participate in the administration of this Act.³³

³¹ For comparative accounts of state intervention in the medical market, see Gerard Kearns, W. Robert Lee and John Rogers, 'The interaction of political and economic factors in the management of urban public health', in Marie C. Nelson and John Rogers (eds), Urbanisation and the Epidemiological Transition (Uppsala 1989), 22-4; Ivan Waddington, 'Medicine, the market and professional autonomy: some aspects of the professionalization of medicine', in Werner Conze and Jürgen Kocka (eds), Bildungsbiarzertum im 19. Jahrhundert. Teil I: Bildungssystem und Professionalisierung in internationalen Vergleichen (Stuttgart 1992 edn), 388-416.


In Germany and the Nordic countries, state intervention placed more constraints on the professional autonomy of medical doctors. On the one hand, the state contributed to the professionalization of medicine, smoothing the way up the social and occupational ladders for medical men. On the other hand, the state actively expanded and regulated the market for medical services throughout the nineteenth century, drawing the medical profession into a network of state-bureaucratic relationships and limiting the autonomy and control they had over their work. In Germany and Denmark the strong role of the state was, to an extent, counterbalanced by the growing middle-class demand for private sector services, and in particular for family medical care provided by general practitioners. The middle classes in both these countries was prosperous enough to pay for qualified medical care and, more importantly, numerous enough to guarantee relatively stable and secure incomes for a large number of general practitioners. In Sweden, Finland and Norway by contrast, the development of private health care services was slow mainly because of low population density, low levels of urbanization and late industrialization. The potential as well as the actual size of the private medical market remained small and the state was instrumental in providing the infrastructure for the expansion of 'modern' medicine and a 'modern' medical profession. The vast majority of medical practitioners, including the medical élite, were in public service, even though many of these doctors also maintained a private practice to supplement their salaries. In Sweden, not less than 90 per cent of medical practitioners held a public appointment in 1880 and about 63 per cent in 1900 and 1920. Half of the medical doctors who were in public service in 1900 were civilian medical officers, either town physicians, provincial physicians or district physicians. Moreover, publicly funded hospitals, which provided about 95 per cent of all hospital beds, employed a large number of medical practitioners.

Thus, the expansion of both preventive and curative medicine in eighteenth- and nineteenth-century Sweden was a case of exchange: the Crown provided medical practitioners with posts and pensions, and medical practitioners did their best to combat epidemics and to maintain the nation's health. While state patronage was undoubtedly advantageous to the medical profession, the state emerged as the main beneficiary of this interdependent relationship, the priorities of the government weighing more heavily in the policy-making than the professional interests of medical doctors. However, in the last decades of the nineteenth century this

34 Women did not enter the profession until the late nineteenth century. For comparison between Northern European countries, see Lagheredningens förslag till förordning angående rätt för qvinna att utöva läkarekallet och förordning angående gift qvinnans rätt att beklada läkaretenst jemte motiv (Helsingfors 1898), 13-7.


situation began to change. The medical profession still derived great prestige from their connection with the state, but at the same time they, together with other professionals such as engineers, successfully promoted a new culture in which science was an important source of cultural authority. The adoption of new scientific knowledge and scientific techniques in public health and clinical medicine was a central part of the process whereby medical doctors took an influential role in shaping health policies at both national and local level. Thus, while in Britain the introduction of new scientific techniques was, to an extent, a vehicle for creating a new social and intellectual hierarchy within the medical profession, for Swedish as well as for Finnish and Norwegian doctors, scientific expertise was a means of making a new deal with the state, of mediating a new boundary settlement which re-negotiated the status of the profession and the state bureaucracy. This boundary settlement which emerged in the late nineteenth and early twentieth centuries provided a basis for the close cooperation between government and medical authority, or between the state and experts in general, which has been so characteristic of the Nordic countries in the twentieth century.

EXECUTIVES

The appearance of impartiality and progressive responsibility which scientific rhetoric could give was also important for public health executives. Executive bodies - City Councils, Public Health Committees and Child Welfare Committees - were presumed to place the common good before vested interests, especially in questions such as the health of the population. These bodies usually sought to appear reasonably disinterested, since failure to do so served to erode their credibility and authority. Individual members of these bodies naturally engaged in party politics and were openly political, advancing the interests of the groups which had elected them. But even they often emphasized, with calculation or conviction, that the reforms they tried to push through would serve the best interest of the whole community.

Fusing group interests and 'the common good' in public health rhetoric was comparatively easy for those groups which were at the centres of political power and cultural production. They exerted a strong influence

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38 On the important role that experts - medical doctors, economists and engineers - had in policy-making in Sweden, see Johannisson, 'The people's health'; Weir and Skocpol, 'State structures'; Torstendahl, 'Engineers'. For a contemporary account, see for example, Brinley Thomas, Monetary Policy and Crises: A Study of Swedish Experience (London 1936), xix-xxi; D. V. Glass, 'Population policies in Scandinavia', Eugenics Review 30 (1938), 89-100. For Britain, see Gail Savage, The Social Construction of Expertise: The English Civil Service and Its Influence, 1919-1939 (Pittsburgh 1996).

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on how 'the best interest of the community' was defined, ensuring that this ideal was never too far away from their own aims and interests. Moreover, many of their policy suggestions seemed neutral and value-free simply because they did not challenge the status quo in society. Keeping things as they are generally appears less political than changing them. Thus, influential groups did not always need to choose their words carefully and to conceal their aspirations and interests. Yet they often preferred to do so. As long as they were able to achieve important aims by expressing their political interests in a 'value-free', scientific form, there was no point in antagonizing opponents and in being too demonstrative in the use of power. By couching proposals in scientific terms, they could claim that the measures they suggested were the right, and by definition the best, answers to urban health problems, not a means of promoting narrow party or group interests. Hence, for example, Conservative or Liberal councillors who opposed municipal intervention in the housing market in the early twentieth century often made a conscious effort to prove that keeping public housing provision to a minimum and improving the health and welfare of city dwellers were not irreconcilable objectives.

Yet to concentrate exclusively on day-to-day policy-making is to risk missing out on what was at least as essential: while new scientific knowledge and techniques were useful in legitimating specific policy decisions, they could also provide 'up-to-date' explanation and justification for the existing political system as a whole. In the late nineteenth and early twentieth centuries, scientific knowledge about the health of the population generally reinforced the view that existing class and gender arrangements, for example the unequal distribution of political power, were essentially natural and non-pathological. The fact that men wielded more political power than women followed logically from natural, 'scientifically proven' differences between the sexes. Opening some new opportunities for women in the political arena was possible, and perhaps even desirable, but absolute equality in terms of political power would clearly be against Nature. Owing to their 'natural disabilities', which ranged from maternity to incapacity to abstract reasoning, it would always be difficult for women to take up the role of policy-makers alongside men. Similarly, while the working class was gradually absorbed into local and national political life, it was often considered 'natural' that middle-class people continued occupying a more exalted place in central and local governments. This arrangement was 'sanctioned' by numerous scientific results which showed that 'talent' was more thinly spread among the working class than among the middle class.

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Those privileged groups and individuals who did not want to explain the current political and social system exclusively in terms of inherited abilities often argued that initiative, skill and effort of individuals were important determinants of social position. They, as Max Weber has put it, wished to see their positions transformed "from purely factual power relations into a cosmos of acquired rights, and to know that they are thus sanctified." New scientific knowledge also offered strong support for their views. For example, statistical information about health, hygiene and habits of different sections of the population, powerfully presented in charts and maps, drew a clear distinction between healthy and unhealthy residential areas and between rational and irrational townspeople. This kind of statistical and scientific knowledge served to build up the confidence of the middle class and to create the rationale for them to make claims for political power at local and national level. Similarly, by 'showing' that the poorest segment of the population possessed neither moral character nor economic independence, this knowledge served to sanction the unequal distribution of political power between the 'respectable' working class and the poor. Health and hygiene were great dividers. In Northern European societies which have embraced the democratic ideal for most of the twentieth century, scientific, 'value-free' knowledge about health and illness has clearly been one of the "mechanisms" which have legitimated power relationships and sanctified social divisions and therefore served to ensure the reproduction of social structures.

On the other hand, science was also important for groups which were on the political and cultural margins. These groups had little influence on how 'the best interest of the community' was defined. Consequently, the reforms they called for and the proposals they put forward tended to clash with the prevailing definitions of the common good and to appear very 'political'. By using scientific language and by emphasizing those aspects of their proposals which were broadly in line with the current notions of the common good, these groups were able to tone down the political flavour of their proposals, making them more acceptable to other policy-makers. Furthermore, drawing upon scientific findings was an important way in which to challenge and transform existing political and social structures. The groups which were excluded from centres of political and social power did not have cultural autonomy, they did not have their own 'language' to describe social problems or their own scientific methods to analyze them. They had to make use of the 'language' and scientific methods of the prevailing culture. Their success in transforming social structures depended on


45 Some feminist writers in the 1970s and 1980s argued (or assumed) that there was a fundamental, universal difference between feminine and masculine moral reasoning and that women had a degree of cultural autonomy. See in particular, Nancy Chodorow, The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender (Berkeley 1978); Carol Gilligan, In a Different Voice: Psychological Theory and Women's Development
whether they were able to draw upon these methods and language for their own ends. For example, both feminists who called for a wider role for women as electors, executives and experts and their opponents who wanted to limit women's role in policy-making often built their campaigns on the same 'scientifically proven' assumption of women's distinctive characteristics. The opponents argued that since women were fundamentally different from men they should concentrate on their role as wives and mothers. The feminists, on the other hand, claimed that society could achieve its full potential only if women were allowed to participate more fully in policy-making. Women, they argued, had unique insights into such issues as health and social welfare and therefore society would benefit from all reforms which opened up new opportunities for them in these policy areas.46

**Beyond the reach of political argument**

While both public health experts and executives regarded science as an important basis for social consensus, they did not necessarily agree on where the boundary between political questions and 'scientific' questions should be drawn. If a specific health problem was perceived as being primarily a technical question to be resolved on the basis of scientific criteria, health officials had the initiative and they were able to define the problem to politicians.47 This led public health officials to emphasize the technical nature of health problems and the value of their own expertise in solving these problems. Politicians naturally enough had more ambiguous feelings about the role of technical expertise in policy-making. In many cases, placing health issues beyond the reach of political argument was also in their interests. More often than not, they preferred to operate quietly, to shelter behind the authority of science, away from the glare of publicity and open party political controversies. Yet politicians did not want the balance of power tipping in the direction of public health officials. They always identified some health problems or aspects of them as political questions which called for lay judgement rather than expert knowledge. In these cases, public health officials usually lost the initiative and sometimes their role was limited to providing scientific legitimation for the policies which health executives were determined to pursue.

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In some policy areas, public health officials were clearly having difficulty claiming authority. The question which frequently sparked political controversy in the early twentieth century was defective housing. In the eyes of many property owners, public health measures which were aimed at alleviating housing problems were only "thinely disguised weapons of a great Socialistic raid upon property", while left-wing critics, for their part, accused health officials of being cowards who did not dare to touch "the pockets of the owners of vile slums." Similarly, public health issues concerning reproduction and sex often inspired heated debates and angry protests. The opponents of birth control insisted that health officials should adhere to their view and save society from moral collapse, whereas the advocates urged them to provide birth control advice and save thousands of women from serious health problems. In these cases, health officials could not win. If they did nothing, they laid themselves open to charges of inaction and political bias; if they did something they were criticized for going too far and, again, being political. Their stance was always contested, no matter how much scientific evidence they produced to support it.

Many other health issues, or important aspects of them, were defined as technical questions and thus lifted from the political scene. Public health officials and leading members of Health Committees may not have theorized about how boundaries of political and technical spheres changed, but they were aware that they could pull health questions away from politics. What they had to do was to convince other policy-makers and the public that there were specialized knowledge about these questions and that they had privileged access to this knowledge. In a debate which was published in the journal of the Society of Medical Officers of Health in Britain in the early 1890s, it was pointed out several times that a medical officer of health often had to convince both executives and the public, "as to the propriety of a certain course of action, and he cannot do this without being himself a master of the subject." In practice, being a master of the subject often meant that health officials made use of new scientific knowledge, techniques and terminology which set health issues outside the easy scrutiny of those who were not themselves within the field. They were often able to determine which issues were put on the agenda for action by drawing attention to some aspects of the problem and by obscuring others. From the point of view of health officials, statistics was particularly useful in policy-making. Statistical methods gave health officials and leading executives an opportunity to define many health questions, to reveal some aspects of them and to conceal the others. At the same time statistics gave the public the impression that they had a means of judging the accomplishments of public

48 Birmingham Public Record Office (BPRO), Birmingham Public Health Committee, minutes 28. 2. 1913 item 1224; Alfred Gough, Objections to the Housing and Town-Planning Bill of the Right Honourable John Burns; and to the Housing of the Working Classes Bill Introduced by Mr. Bowerman: With Birmingham's Experience of the Housing Acts (Birmingham 1908), 2; Göteborgs Stadsfullmäktiges Handlingar 1913:337; 1923:328 and minutes 13. 9. 1923 and discussion; Gösta Göthlin, 'Några bostadshygieniska reformkrav', Göteborgs Läkaresällskaps förhandlingar 13. 9., Hygiea 79 (1917) 21, 1151-69.

49 'Kvinnekongressen i Stockholm', Ny Tid 7. 8. 1908; 'Sexuell hygien: Dr Alma Sundqvists föredrag å soc.dem. kvinnokongressen', Ny Tid 11. 8. 1908; 'Det tomma intet', Ny Tid 9. 5. 1910; 'Mot ofraktsamhets-propagandan: gårdagens stora opinionsmöte', Göteborgs-Posten 9. 5. 1910; BPRO, Birmingham Maternity and Child Welfare Committee, minutes 5. 3. 1931 item 585; 13. 3. 1931 item 590.

50 Ransome, Armstrong and Sykes, 'The training and qualification', the quote 243.
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health authorities. Statistics was supposed to provide knowledge which anyone could read, thoroughly public knowledge appropriate for new democratic societies.  

——— CONSTRUCTED KNOWLEDGE, ENGINEERED IGNORANCE ———

There was nothing inevitable in the important role which science and (scientific) medicine played in the construction of public health programmes in the early twentieth century. In the 1850s and 1860s, medicine and science had not been established sources of authority to which public health experts and executives could automatically have turned for the legitimation of their programmes. By the early twentieth century, they had become the ultimate arbiters in many health and social matters, and health authorities themselves had helped to bring about this change. For example, late nineteenth-century bacteriological discoveries played powerful part in 'directing' and legitimating health policies, since they suited, or could be 'constructed' to suit, the position and purposes of public health authorities. These bodies were involved with creating a social and political setting in which the questions that bacteriologists asked and the solutions they could offer appeared important and efficient. Without this setting the hunt for germs would never have attracted so many bright minds. Pre-eminent bacteriologists such as Louis Pasteur and Robert Koch would not have made their discoveries, or if they had made them, these discoveries would have remained for ever in their small laboratories in Pouilly-le-Fort and Wollstein. No one would have been interested in these inventions, nobody would have diffused them.

Alongside bacteriology, many other branches of medicine, from paediatrics to psychiatry, became more prominent in municipal policy-making during the period 1880-1940. Public health experts and executives, who wanted to develop stronger claims to authority not only in traditional public health matters such as environmental problems and infectious diseases but also over wider health and social issues, increasingly invoked the findings of different branches of medicine to support their new proposals and plans. This in turn gave these specialities more credibility and visibility as a source of judgement in society. Furthermore, public health authorities promoted the use of statistics in the analysis of health and social problems. In producing charts and maps to analyze and illustrate urban health problems, health authorities usually

51 Porter, Trust in Numbers. See also Theodore M Porter, 'The management of society by numbers', in Krige and Pestre (eds), Science in the Twentieth Century, 97-110.

52 Latour, The Pasteurization; Evans, Death in Hamburg, 264-75; Johannisson, 'Folkhälsa', 139-45. See also, Lindsay Granshaw, 'Upon this principle I have based a practice': the development and reception of antisepsis in Britain, 1867-90, in Pickstone (ed.), Medical Innovations, 17-46; Bruno Latour, Science in Action: How to Follow Scientists and Engineers through Society (Milton Keynes 1987); Christopher Hamlin, What Becomes of Pollution: Adversary Science and the Controversy on the Self-Purification of Rivers in Britain, 1850-1900 (New York 1987).

53 For the growing emphasis on personal medical care in public health policy in the early twentieth century, see for example, Lewis, What Price Community Medicine?, 1-10; idem, 'Providers'; Steven Cherry, Medical Services and the Hospitals in Britain, 1860-1939 (Cambridge 1996), 17-20, 48-51; Kock (ed.), Medicinalväsendet i Sverige; Johannisson, 'Folkhälsa'.
contented themselves with the use of relatively simple statistical methods. However, many leading public health experts and executives especially in Britain were also involved in eugenics societies and groups which gave a strong impetus to the development of statistical theory and sophisticated mathematical methods of treating data.54

Clearly, health experts and executives were actively building up the prestige of science in policy-making. Yet it is not to say that invoking the authority of science was always a conscious strategy to exercise power and a calculated enterprise to control the life of the city. The new scientific policy-making culture was much more than a mere smoke screen behind which experts and executives could advance political ideals which they considered important. Scientific rhetoric would never have been so effective and widely used as it was (and is), if experts, executives and the public had not truly believed in the ideal of science as a value-free means of analyzing and solving social and health problems. Despite their apparent scepticism about some specific research findings, they all retained their confidence in science in general.55 As Bruno Latour has pointed out, "(w)e would like to make decisions other than through compromise, drift, and uncertainty. We would like to feel that somewhere, in addition to the chaotic confusion of power relations, there are rational relations."56 In the early twentieth century, both policy-makers and the public clearly believed that there were rational relations and that science was able to reveal them.

It was supposed that scientific investigation would yield objective and neutral knowledge about the order of Society and in particular about the order of Nature.57 Medical and public health research, it was thought, would get at the real causes of diseases and suggest effective and appropriate responses to them. Most people agreed that, in the case of many health problems, this ultimate aim had not yet been achieved and probably would not be achieved in the near future. Very few studies and reports published in the field of medicine and public health in the early twentieth century made a pretence of providing complete and fully accurate description of such health problems as infant mortality, tuberculosis or cancer. By contrast, most experts readily acknowledged that they were in the dark about many aspects of these problems and that more research was needed to fill the gaps in the existing knowledge. Sometimes they even exaggerated their ignorance. Yet it was generally believed, firstly, that the existing knowledge was accurate and, secondly, that it was possible


57 Ludmilla Jordanova, 'Introduction', in Ludmilla Jordanova (ed.), Languages of Nature: Critical Essays on Science and Literature (London 1986), 15-47. For the growing interest in social research concerning the nature of urban society and urban life, see Savage and Warde, Urban Sociology, 7-22; Topalov, 'The city'. Savage and Warde have pointed out that "sociology emerged in the early twentieth century as a discipline primarily concerned with the nature of urban life and the analysis of what might be loosely be termed 'urban problems'."
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for medical and public health experts to fill the gaps. Scientists and other experts would gradually advance the frontiers of knowledge, working out the whole truth about health problems and finding right answers to them. This optimism was clearly strengthened by late nineteenth-century advances in bacteriology such as the discovery of the causal microbes for cholera, tuberculosis and diphtheria which were, in the eyes of many contemporaries, quantum leaps in the realization of the Natural Order.

In the course of the twentieth century the image of science and scientists was to change. The idealized view of the life of science - scientists keeping themselves at a safe distance from politics and dedicating their lives to the relentless pursuit of accurate, value-free knowledge - have clashed with what people have seen and experienced. Not only have scientists been politically active outside their laboratories and studies, but they have also, wittingly and unwittingly, 'allowed' political and social concerns to affect the direction and content of their work. Nazi science, Soviet science and late twentieth century Big Science - military research choreographing World War III, medical science promoting expensive high-tech strategies, and tobacco-companies spending millions on research in order to buy time - have clearly shown that scientists have been ready to oblige basically any political rule or commercial interest with scientific legitimation. "Hertz rent-a-scientist", as *Time* magazine has called the phenomenon, offers strong support for the view that "the scientist, no less than other mortals, is a *zoon politikon*, sharing the hopes and aspirations, frailties and foibles, of other men and women." Similarly, scientific knowledge and especially its applications are no longer regarded as innocent, and many writers have raised the question of whether science is just 'other means of politics'. While this philosophical question may be open to debate, it is certain that many political and social aims which could not have been achieved through political politics have been achieved through scientific, 'neutral' policies and procedures.

These critical debates, which initially arose out of the social and political upheavals of the 1960s and 1970s, have inspired a wealth of studies on what kind of knowledge science actually provides and how this knowledge affects societies. Theorists who still defend the value-neutrality of science emphasize, firstly, that it is essential to distinguish the direction of science and the content of science. They argue that political and economic concerns can affect only the direction, not the content. Secondly, the defenders of value-neutrality

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58 What contemporaries meant by objectivity and truth differed from occasion to another. In many cases, objectivity and truth were clearly perceived as 'absolute objectivity' (knowledge is objective when it represents things as they are, when it mirrors accurately the empirical world), but sometimes these words were clearly used as a synonym for 'disciplinary objectivity' (knowledge is objective when the members of particular research community agree on it). In the early twentieth century, health experts, executives and the public did not make a clear distinction between these two types of objectivity. Allan Megill, 'Introduction: four senses of objectivity', *Annals of Scholarship* 8 (1991), 301-20.


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maintain that it is important to make a clear distinction between pure science and the practice of science. The pure science, they argue, is always neutral but it can be used for both good and bad ends. In other words, it can be used or abused.61

Sophisticated critics have undermined both these arguments, and the contributions which feminist writers have made to this debate have been particularly important.62 In seeking to uncover the processes which have ensured the continuance of the economic and social subordination of women, feminist researchers have analysed, for example, the production and deployment of scientific knowledge. They have shown, through theoretical argument and empirical studies, that scientific knowledge and its applications have played a major role in maintaining and legitimating gender hierarchies of power. An important reason why science has been effective in reinforcing the existing structures of inequality is that its direction, content and practice have all been affected by social and political interests and, in this particular case, by historically specific ideologies of gender. Feminist researchers have been able to point out an androcentric bias not only in the choice of research topics, but also in the design of experiments and in the interpretation and application of results. Scientists and other experts have clearly reproduced, at the level of 'universal' scientific knowledge, historically specific assumptions about femininity and masculinity. For example, at the turn of the century, when women were outside the official political system, legally and economically dependent on their husbands and discriminated in workplaces, 'value-free' science served to justify women's exclusion from political power, to legitimate her inequality in the family and to provide rationale for her secondary status in the labour market.

Social sciences played a part in legitimizing women's role and position, but natural sciences had a more important role, biomedical sciences being the final arbiters in many issues relating to the role of women. Biomedical sciences were influential in 'defining' the social roles of women and men, since the ultimate authority which they invoked was Nature.63 "And nature was a difficult authority to challenge."64 The

61 For further discussion and criticism, see Sandra Harding, Whose Science? Whose Knowledge? Thinking from Women's Lives (Milton Keynes 1991); Tiles, 'A Science', the quote, 298; MacKenzie, Statistics in Britain, 2-4; Jordanova, 'The social construction'.

62 For general criticism, see footnote 55. See also, Roger Smith, Inhibition: History and Meaning in the Sciences of Mind and Brain (Berkeley 1992).

issue around which this debate has revolved is sexual difference. Most present-day feminists distinguish between biological sexual difference which is a natural phenomenon and knowledge about this difference, gender, which is a social and cultural construct. Gender, as Joan Scott argues, is the knowledge which establishes meanings for natural physical differences between women and men. "These meanings vary across cultures, social groups, and time, since nothing about the body ... determines univocally how social divisions will be shaped." Thus, unequal distribution of political power between men and women or a sexual division of labour at home are (human) constructs, not natural state of affairs. Science and its applications, especially in the early twentieth century but also, to an extent, at the present time, have promoted a very different view. They have established and consolidated sexual difference as a natural phenomenon and a natural fact which cannot be altered, which cannot have different meanings in different cultures and which determines the social roles of women and men. The first basic lesson to be learned, early twentieth-century science claimed, was that women were inherently different from men, lacking some essential characteristics which made the rational, political citizen. Secondly, all women, irrespective of class, race and age, were fundamentally similar to each other. They shared some essential inherent characteristics which determined the role to which they were best suited: mothering, taking care of the well-being of other people. Women who challenged this vision wanted "biologically unnatural changes that would bring grief to the human race." Science has also legitimized other structures of inequality. For example, historians and anthropologists have shown that the direction, content and practice of medical science served to provide rationale for imperialism and thus to preserve it from criticism and challenge. As David Arnold has put it: "(t)hrough their voluminous studies of medicine and illness, doctors and surgeons helped to form and give a seemingly scientific precision to abiding impressions of India as a land of dirt and disease, of lethargy and superstition,

Whose Science? For social sciences, see Sondra Farganis, 'Feminism and the reconstruction of social science', in Alison M. Jaggar and Susan R. Bordo (eds), Gender/Body/Knowledge: Feminist Reconstructions of Being and Knowing (New Brunswick 1992 printing). See also, Proctor, Value-Free Science: Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth (eds), Body/Politics: Women and the Discourses of Science (New York 1990).

64 Joan Wallach Scott, Only Paradoxes to Offer: French Feminists and the Rights of Man (Cambridge Mass. 1996), x.

65 Scott, Gender, 1-11, the quote 2. See also Jordanova, Sexual Visions; Mary Poovey, Uneven Developments: The Ideological Work of Gender in Mid-Victorian England (Chicago 1988), 1-23. Some feminist writers have strongly criticized the theoretical approach chosen by Scott, Jordanova and Poovey. For example June Purvis attacks, to my mind unsuccessfully, their views and argues that feminists writers should focus on women not on gender. June Purvis, 'From "women worthies" to poststructuralism? Debate and controversy in women's history in Britain', in Purvis (ed.), Women's History, 1-22.

66 See, for example, Jordanova, Sexual Visions; Moscucci, The Science of Woman, 36-41.

67 Fausto-Sterling, Myths of Gender, 4.

68 For discussion, see David Arnold, Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India (Berkeley 1993); idem, 'Introduction: disease, medicine and empire', and Michael Worboys, 'The discovery of colonial malnutrition between the wars', in David Arnold (ed.), Imperial Medicine and Indigenous Societies (Manchester 1988), 1-26 and 208-25; Mark Harrison, Public Health in British India: Anglo-Indian Preventative Medicine (Cambridge 1994), especially chapter 2; Good, Medicine. For non-Western responses to Western medicine, see Andrew Cunningham and Bridie Andrews, 'Introduction: Western medicine as contested knowledge', in Andrew Cunningham and Bridie Andrews (eds), Western Medicine as Contested Knowledge (Manchester 1997), 1-23.
of backwardness and barbarity - images which have remained so powerful even in the contemporary understanding of India - and to contrast this Orientalized India with coolheaded rationality and science, the purposeful dynamism, and the paternalistic humanitarianism of the West.”

However, while late nineteenth- and early twentieth-century science and scientists were confident that sexual difference belonged to the realm of Nature, they were less certain about whether racial and class differences were natural or social. In medical and public health literature which was concerned with indigenous peoples in the colonial world or with the urban poor in Europe, the view that race and class hierarchies were due to social and cultural factors was often inextricably interwoven with the view that these hierarchies were natural. Sometimes indigenous peoples and 'slum dwellers' were seen as innately inferior, as biologically different from their superiors. Sometimes they were defined as “backward people” who lagged behind the “advanced” races and social groups in the evolutionary process but who could improve themselves if they followed in the footsteps of the leaders. Finally, in some cases, race and class hierarchies were attributed largely to cultural and environmental factors such as poverty and lack of education. Irrespective of where exactly the emphasis was placed, medical science and its applications conceptualized indigenous peoples and societies so that imperialism seemed justified and defined slum dwellers and slums so that municipal intervention were legitimated. Florence Nightingale, who was involved in creating new health services in both Britain and India in the second half of the nineteenth century, made it plain that to improve the health and well-being of the population, health care system should control much more than diseases. A district nurse working in the slums of the British cities were expected to bring "order and cleanliness with her into the abodes of the most disorderly." In India the task was even more fundamental, as Nightingale pointed out: "how to create a public health department for India: how to bring a higher civilization into India ... That would be creating India anew.”

The 'slum dwellers' apart, class difference was mainly seen as a social rather than a natural phenomenon, a (human) construct rather than a (natural) given. Yet the fact that medical science did not speak about class in the same 'universalizing' and 'naturalizing' utterances it used for gender does not mean that its role in legitimizing and depoliticizing class hierarchies was unimportant. Basic parameters of the existing economic system and institutions has influence on what is taken as knowledge in society. Thus, the direction, content

69 Arnold, Colonizing the Body, 292.

70 Harris, Private Lives, 233-7; Bland, Banishing the Beast, 73-6; Arnold, 'Introduction'.


and practice of Western medicine have been, to an extent, guided by the parameters of a capitalist economy, whereas, for example Soviet medicine was influenced by the parameters of a socialist economy. In both these systems, medical knowledge and its applications have reinforced people's "ability not to see" inequality, social distress and economic waste for which their own economic system is responsible. At the same time medicine has highlighted the bedrock principles and values of these economic systems, for example Western medicine has emphasized the value of rationally based entrepreneurship. Medicine, both research and practice, has sought to solve health problems in the existing institutional contexts, and thus it has served to maintain existing structures, including class hierarchies. Although class has usually been seen as a social phenomenon, much influential research which defined it as 'natural' was done during the period reviewed here. In particular, studies which were concerned with 'general intelligence' turned class into a biological phenomenon, arguing that people's social position was determined by their inherited 'intelligence'. These studies had a major influence, for example, on educational policies.

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This study explores how early twentieth-century campaigns against infant mortality and tuberculosis served to depoliticize and 'naturalize' local economic arrangements, social structures and moral norms. The focus is therefore on different, and often conflicting, objectives of municipal health policy and on the complex ways in which scientific knowledge was used to reconcile and depoliticize these goals. By reconstructing scientific knowledge to suit political purposes, health authorities were able to represent themselves as active promoters of health and welfare even when they clearly gave priority to the economic interests of local businesses or to the professional aspirations of medical doctors. By sheltering behind the authority of scientific knowledge, they could claim that they concentrated on improving the health of men, women and children, while their primary focus may have been to maintain the work ethic and to buttress the family institution and its hierarchy of roles. Finally, health authorities could argue that they were active agents in the creation of collective identity and social solidarity in their cities, although their campaigns often determinedly disorganized collectivities of citizens in the name of health.

Processes whereby different political and social concerns became embedded in 'value-free' health policy are examined in Chapters 4 and 5 which occupy a large proportion of this study. Chapter 4 looks at infant welfare campaigns in early twentieth-century Birmingham and Gothenburg, tracing the construction of these campaigns through competing visions of public health experts, executives and other social reformers. The purpose is to examine, firstly, how scientific knowledge was used to link the well-being of infants to the

73 See, for example, Jordanova, 'Introduction', 25.
74 Waitzkin, 'A critical theory'.
75 Norton, 'Psychologists and class'; Hendrick, Children, 65-73.
efforts to regulate working-class family life and gender roles in particular. Secondly, the chapter discusses the 
ways in which the promotion of infant welfare was reconciled with the aspirations of the medical profession 
and with the needs of the local economy. Chapter 5 examines how the Birmingham and Gothenburg 
authorities defined and responded to the problem of tuberculosis in the early twentieth century. The main 
purpose of this chapter is to discuss the extent to which anti-tuberculosis campaigns served to regulate urban 
life in general and to legitimate municipal intervention or non-intervention in the homes and in the housing 
market and the medical market. The foci of attention in this chapter are the relations between social classes 
and between adults and children. Ethnic relations have been left aside in both Chapter 4 and 5 mainly because 
there were no sizeable ethnic minorities in Gothenburg or Birmingham in the period reviewed here. In the 
nineteenth century, Gothenburg was an international town, but foreigners seemed to integrate quickly into 
society or, alternatively, they were so wealthy and powerful that the question of whether they assimilated 
themselves is irrelevant, at least from the point of view of public health. In the first decades of the twentieth 
century, there were a relatively small number of foreign nationals in the town, mainly from the other Nordic 
countries and from Germany and Russia. In early twentieth-century Birmingham, the Irish were the biggest 
foreign group, but they did not figure prominently in the municipal health policy. The Medical Officer of 
Health hardly ever mentioned the Irish or other ethnic minorities in his reports.76

Before examining the role that municipal health policy played in regulating urban life, it is necessary to 
discuss the economic, social and administrative contexts in which health policies were constructed in early 
twentieth-century Birmingham and Gothenburg. Chapter 2 examines diverse socio-economic conditions 
within these cities, concentrating especially on the aspects which were likely to influence on how health 
problems were understood and defined. The chapter deals with demographic pressures to which health policy 
was subject in Birmingham and Gothenburg, examines spatial arrangements in these cities, sheds light on 
housing conditions and work opportunities, and analyses family patterns and ideals. However, the 
construction of health policies was affected not only by social relations but also by administrative structures 
and policy legacies. In particular, pre-existing administrative arrangements and policy legacies served as a 
catalyst and an impediment to the formulation of new ideas and policies. By analyzing government structures 
and public health traditions in Britain and Sweden and by describing widely held views about the appropriate 
role of health authorities, Chapter 3 opens an opportunity to identify and discuss some fundamental patterns 
and continuities in British and Swedish public health policies.77


77 Theda Skocpol, 'Bringing the state back in: strategies of analysis in current research', in Evans, Rueschemeyer and Skocpol (eds), Bringing the State Back In, 3-37; idem, Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States (Cambridge Mass. 1992). See also, Sears, "To teach them how to live"; Göran Therborn, Borgarklass och byråkrati i Sverige: Anteckningar om en sötshenhistoria (Lund 1989).
The comparative international approach, chosen in this study, provides a fresh perspective on how public health authorities organized and regulated the life of the city and mediated conflicts in urban society. A comparative study opens an opportunity to explore why health authorities knew what they knew, since it shows very clearly that they could have known otherwise. By revealing what happened but also what did not, a comparative approach clarifies the choices British and Swedish health officials made - what they accepted or just assumed and what they rejected. Furthermore, since this study concentrates on two cities, it is focused enough to give justice to the full complexity of decision-making and to illuminate a wide range of political, social and moral concerns which were threaded through public health campaigns. On the other hand, two important themes have been deliberately left outside the scope of this study. Firstly, this research concentrates almost exclusively on 'political' origins and 'political' repercussions of public health policies and says very little about the life and death consequences of these policies. In other words, the aim of this research is not to discuss how efficient the measures taken in Birmingham and Gothenburg were in reducing mortality and morbidity rates and in improving the health and well-being of the city population. The attempt is to explore how these measures served to regulate the life of the city.

Secondly, this research does not discuss in detail the party politics in Birmingham and Gothenburg or the aims and achievements of different political parties in public health arena. Party politics has been left out partly because this study concentrates on the early twentieth century, when the City Council in both Birmingham and Gothenburg was governed by Liberals and Conservatives and the key positions in municipal policy-making were occupied by men of substantial wealth and influence. Had the subject of this study been public health campaigns which were launched in the 1920s and 1930s, it would have been more important to discuss also party politics. In Birmingham, the Conservatives and Liberals continued to dominate the City Council in the 1920s and 1930s, while in Gothenburg these parties had to relinquish their power. From 1919, the Social Democrats were the largest party in Gothenburg. Another reason for excluding party

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78 For example, George Rosen has argued that the task of the historian of public health is "to investigate and demonstrate how economic, social, medical, and scientific events interact to create specific public health developments". George Rosen, From Medical Police to Social Medicine: Essays on the History of Health Care (New York 1974), 200.

79 Thomas McKeown and many other researchers in his wake have claimed that public health measures were only of secondary importance and that other factors such as improved nutritional standard were to be given most of the credit for the decline in mortality in the late nineteenth and early twentieth centuries. This view has been challenged, for example, by Gerry Kearns, Simon Szreter, Samuel Preston and Etienne van de Walle who have conceived sanitary measures as a key determinant of receding death rates. Thomas McKeown, The Modern Rise of Population (London 1976), 110-42, 152-63; Gerry Kearns, 'The urban penalty and the population history of England', in Brändström and Tedebrand (eds), Society, Health and Population, 213-36; idem, 'Le handicap urbain et le déclin de la mortalité en Angleterre et au Pays de Galles 1851-1900', Annales de Démographie Historique (1993), 75-105; Simon Szreter, 'The importance of social intervention in Britain's mortality decline c. 1850-1914: a reinterpretation of the role of public health', Social History of Medicine 1 (1988), 1-37; Samuel H. Preston and Etienne van der Walle, 'Urban French mortality in the nineteenth century', Population Studies 32 (1978), 275-97.

politics is that an international comparison is a problematic method of analyzing the influence of political parties on welfare policies. Theda Skocpol and Susan Pedersen, who have used an approach of this type, have argued that "working-class strength" does not correlate in any simple way with social policy. However, many writers who have concentrated on a single country, have argued that the degree of working-class strength is a key determinant of welfare policies. For example, Martin Powell, who has studied regional variations in health care provision in inter-war Britain, has shown that the political constellation of the City Council influenced the comprehensiveness and the quality of services. Lara Marks has examined the same theme in her study on maternal and infant welfare services in four boroughs in London. She argues that health care provisions were dependent on the political outlook and social relations within each area.

Although this study does not discuss the party politics, it explores the ways in which health authorities' views were contested. Authorities' views mattered in both Birmingham and Gothenburg, but they were by no means unquestioned. Chapter 6 examines how different social groups - middle-class women and working-class women and men - challenged authorities' views or, perhaps more importantly, how these groups seized on contradictions in health policy to change things and to mobilize their own power. Useful analytical tools for exploring these questions are provided by writers who have assessed Michel Foucault's theory of power and criticized its one-dimensional nature.

Jürgen Habermas, whose own work on welfare policies has been influenced by Foucault's insights, attacks Foucault for placing too much emphasis on disciplinary forms of control at the expense of other forms of power. In particular, Habermas castigates Foucault for ignoring legal regulation. As Foucault completely overlooks the legal means by which the exercise of power has been regulated and structured, he cannot see, let alone analyze, one of the principal paradoxes of societal modernization. The very (legal) means which secure freedom, Habermas argues, are often the means through which freedom is put in jeopardy.

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81 Pedersen, The Origins of the Welfare State; Weir and Skocpol, 'State structures'.
83 Lara Marks, Metropolitan Maternity: Maternal and Infant Welfare Services in Early Twentieth Century London (Amsterdam 1996).
84 In his final work - The Use of Pleasure and The Care of the Self - Foucault acknowledges and seeks to overcome some of the analytical limitations in his earlier work and in particular the limitations which led to an understanding of power as a purely prohibitory and repressive entity. For a negative definition of power, see in particular Michel Foucault, Discipline and Punish: The Birth of the Prison (London 1991). For a reassessment, see Michel Foucault, The Use of Pleasure: The History of Sexuality. Vol II (London 1992); idem, The Care of the Self: The History of Sexuality. Vol. III (London 1990). See also McNay, Foucault and Feminism, 38-42, 59-62.
85 Jürgen Habermas, Der philosophische Diskurs der Moderne: Zwölf Vorlesungen (Frankfurt 1985), 336-43. For Habermas' analysis of welfare techniques, see Jürgen Habermas, The New Conservatism: Cultural Criticism and the Historians' Debate (Cambridge 1989) and in particular the chapter 'The new obscurity: the crisis of the welfare state and the exhaustion of utopian energies'; idem, The Theory of Communicative Action. Vol. 2: Lifeworld and
Walkowitz, who has looked at prostitution and representations of sexual danger in Victorian Britain, gives a graphic example of this paradox. Legislation which aimed at protecting young working-class women and girls from sexual abuse, in particular the Criminal Law Amendment Act of 1885 and the White Slavery Act of 1912, gave police greater summary jurisdiction over these same women. Yet this causal chain can always be reversed. While legal regulation has restricted the freedom of individuals, it, Habermas claims, has also meant important gains in liberality and legal security. In the field of medicine and public health, legalization of birth control advice and abortion clearly illustrate this point. These reforms certainly cannot be reduced to a strategy by which women's bodies were disciplined or by which women's secondary status in society was confirmed. These changes secured them legal freedoms as well as social and psychological freedoms. As Richard Titmuss put it as early as the 1950s, birth control brought about "nothing less than a revolutionary enlargement of freedom for women."

By depicting power as "a system of overlapping contradictions" Ellen Willis provides a useful framework to explain how groups that were on the political and cultural margin managed to achieve rights and freedoms. These groups seized on instabilities in the system, for instance in scientific knowledge about health and illness, to mobilize their own power. For instance, the ideal of female chastity, which permeated all official knowledge about prostitution and venereal diseases, reinforced female subordination but it also gave women power to attack male double standard. The protection of motherhood, one of the key conceptions in the infant and maternal welfare campaigns, served to strengthen the traditional division of labour in families. Yet women used this cultural conception also as a political tool for claiming new roles for themselves in policy-making and for exposing how far from the ideal the reality of many mothers' daily life was. The knowledge about and the campaign against AIDS in the 1980s and 1990s heightened the stigma

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86 Judith R. Walkowitz, Prostitution and Victorian Society: Women, Class and the State (Cambridge 1982 edn), 246-56; idem, City of Dreadful Delight, 102-5, 121-34.

87 Habermas, Der philosophische Diskurs, 340.

88 McNay, Foucault and Feminism, 44-5.


90 Catharine A. MacKinnon, 'Desire and power: a feminist perspective' and Ellen Willis, 'Comment', in Gary Nelson and Lawrence Grossberg (eds), Marxism and the Interpretation of Culture (London 1988), 105-16 and 117-9; McNay, Foucault and Feminism, 38-47.

91 Caroll Smith-Rosenberg, 'Writing history: language, class and gender', in Teresa de Lauretis (ed.), Feminist Studies/Critical Studies (Bloomington 1986); Walkowitz, Prostitution and Victorian Society, 246-56. See also, Bland, Banishing the Beast.

92 Gisela Bock and Pat Thane (eds), Maternity and Gender Policies: Women and the Rise of the European Welfare States, 1880s-1950s (London 1991); Koven and Michel (eds), Mothers of a New World; Christoph Sachße, Mütterlichkeit als Beruf: Sozialarbeit, Sozialreform und Frauenbewegung (Frankfurt 1986).
of homosexuals but it also heightened their respectability. As Foucault has argued, "discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it. In like manner, silence and secrecy are a shelter for power, anchoring its prohibitions; but they also loosen its holds and provide for relatively obscure areas of tolerance."

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93 For discussion, see Dennis Altman, 'Legitimation through disaster: AIDS and the gay movement', in Elizabeth Fee and Daniel M. Fox (eds), *AIDS: The Burdens of History* (Berkeley 1988), 301-15.

"Everyone who has lived in Birmingham a few years laughs at the idea that it is the best governed city in the world. The Birmingham which visitors pretend to write of is not the Birmingham which the masses know. Our few central streets and public places, and the parks and mansions of Edgbaston do not represent the Midland metropolis."

"Let the visitor dwell upon the scene at Bordesley or Duddeston - upon the dingy, malodorous, overcrowded dens, the reeking streets, the filthy alleys, and the unpromising multitude."

_Daily Gazette, 1888_

Images of cities are important political instruments. Late nineteenth-century Birmingham was often characterized as "the best-governed city in the world"; a reputation which was most convenient for Birmingham municipal managers and which says much about their skills to manage the image of their city. Reforms that Joseph Chamberlain, the Mayor of Birmingham from 1873 to 1876, and his allies and political heirs introduced did not always achieve the objectives they were meant to achieve. Nor did these reforms break new ground. Glasgow, Liverpool and Manchester were several years ahead of Birmingham in widening the sphere of local government action. However, the skilful way in which Chamberlain constructed and manipulated the meaning of municipal reforms was not surpassed by any contemporary civic leader. Chamberlain persuaded policy-makers and the public to think of town improvement schemes as expressions of modernity and progressive responsibility. As a result, the Birmingham city administration, which had woken up relatively late to the possibilities of municipal enterprise, appeared innovative and forward-looking, and the city itself, "one of the ugliest towns in England," emerged as a respectable, even glamorous metropolis.

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1 Quoted in J. A. Fallows, _The Housing of the Poor_ (Birmingham 1899), 3.

2 Mike Savage and Alan Warde, _Urban Sociology, Capitalism and Modernity_ (London 1993), 146.


Predictably, the name Birmingham did not conjure up images of efficient, good governance for everyone. In particular, Chamberlain's view that the Birmingham city government had served the best interests of the whole community and had made "the lives of all its citizens somewhat better, somewhat nobler and somewhat happier" was strongly questioned. Opponents from the right and the left, including a Conservative newspaper the Daily Gazette and a Socialist writer J. A. Fallows, were united in their conviction that Birmingham's good reputation was built on rather shaky premises. They argued that the beneficial effects of the new civic policy were largely restricted to the central business area and middle-class suburbs such as Edgbaston, while the other parts of the city either remained untouched by the reforms or actually suffered from them. These concerted efforts to contest the well-known image give an idea of how great an asset Birmingham's good reputation was to Chamberlain and his successors and, more generally, how crucial a role images of this kind played in local and national politics.

Another example of the importance of images is Birmingham's reputation as "the workshop of the world". This old image was often exploited for attracting new industries to the city. The message which the Birmingham civic leaders sought to convey was that their city, with its diverse and adaptable small businesses, skilled workforce, harmonious industrial relations and good public services, had more to offer modern industrial enterprises than other provincial cities. Advertisements, run by the Birmingham Corporation in the late 1920s, urged businessmen and industrialists to "(k)eep Birmingham in mind - for the establishment of manufactories and industrial development." Birmingham was, the advertisement pointed out, "the home of the skilled artisan" and "the birthplace of the industrial revolution", which had "good and abundant water supply, excellent transport facilities, and efficient gas and electricity services for power, heating, and lighting purposes." These campaigns which publicized Birmingham and its advantages achieved their principal aim: they sold the business community on the idea that the Midland metropolis, which was governed by Conservatives and Liberal Unionists, accommodated industrial enterprises. While many old manufacturing towns and cities languished in economic backwaters in the 1920s and 1930s, Birmingham stayed in the industrial limelight, attracting new industries and trades. "The workshop of the world" grew smoothly into a modern industrial city which produced electrical equipment, bicycles and Austin cars.

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7 W. S. Body (ed.), *Birmingham and its Civic Managers: The Departmental Doings of the City Council* (Birmingham 1928), 146.

In Gothenburg, rather than dwelling on the achievements of progressive city administrators, the élites emphasized the cosmopolitan atmosphere of their town. Nineteenth-century Gothenburg was often described as "the England of Sweden" or "Little London", since many of the town's wealthy merchants and industrialists had emigrated to Sweden from Scotland or England. Gibsons, Keillers, Dicksons, Barcleys and other British families profoundly affected the economic and political life of their adopted home town. For example, they made Gothenburg a stronghold of liberalism, which meant that even the poorest section of the town population felt the effects of international reforming impulses. In Gothenburg the role of private charity in relieving poverty was exceptionally important, whereas the public relief system was renowned for its meanness. Following the principles of the British Poor Law of 1834, the Gothenburg Poor Relief Board had inaugurated a new stricter relief system in the 1860s, several years before the Swedish Parliament passed a law introducing similar stringent rules.

In the late nineteenth and early twentieth centuries, when the British and other foreigners had largely assimilated themselves and become Swedes, close international contacts remained an important feature of Gothenburg's image. The city was "the gateway to the world" for Swedish pulp and paper and for a million emigrants. At the same time, it was "the gateway to Sweden" for American cotton, British coal and Brazilian coffee and for many foreign visitors. Gothenburg was also successful in attracting export industries, mainly shipbuilding, metalworking and mechanical engineering. As a bustling centre of commerce and export industries, Gothenburg took its place high up in the Swedish urban hierarchy, below the capital city Stockholm but clearly above the industrial towns of Malmö and Norrköping. Similarities between the economic structures of Stockholm and Gothenburg were great enough to foster rivalry between these two cities, while Malmö and Norrköping, with their narrower economic and employment bases, could not mount a serious challenge to the capital.

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12 Fritz, *Från handelsstad till industristad*, 185-91; Olsson, *Från industristad till tjänstestad*, 77-82.
For local élites, the image of Gothenburg as an international town was an invaluable political tool. It facilitated economic, political and intellectual contacts with western Europe and, in local politics, this image was used to push through substantial public projects such as the enlargement and improvement of port facilities that ordinary tax-payers were hesitant to accept. These infrastructural investments, which put heavy demands on the public purse, were of vital importance to the economic success of the Gothenburg élites in the nineteenth and early twentieth centuries. The close integration into the world market gave Gothenburg wealth and prestige, but it also left the city's economy susceptible to sharp fluctuations. The volatility of the local economy and the instability of employment prospects, in turn, may have contributed to some dramatic changes and bitter conflicts which took place in the party political arena. "The wealthy Gothenburg", the birth place of the Swedish bourgeoisie and the stronghold of liberalism, gradually developed into "Sweden's reddest city". From 1919, the Social Democratic Party was the largest group in the Gothenburg City Council and the Communist parties also played an important role in local politics. Although policies which the Social Democrats pursued were moderate and practical rather than 'red', they often met a cool response from both the right and the left. If their policies were not criticized by the Liberals, Conservatives or the Communists' national faction, they were attacked by extremist groups. Both the extreme left, the Communists who followed the Comintern line, and the extreme right, the National Socialists, had a stronger foothold in Gothenburg than in any other large Swedish town.

These images of Gothenburg and Birmingham, irrespective of how much substance there was to them, can only give a narrowly focused picture of the life of the cities. As the critics often pointed out, there were other important stories about Birmingham and Gothenburg. This chapter broadens the picture by looking at different aspects of urban development. It deals with the physical and spatial configuration of these cities, discusses demographic trends, economic development and social structures, analyses 'political' and moral cultures, and traces the development of municipal policies concerning housing and social welfare. The main aims of this chapter are, firstly, to provide the basis for discussion as to how political, social and moral concerns were threaded through the early twentieth-century infant welfare movement and anti-tuberculosis campaign and through the scientific knowledge in which these campaigns were anchored. Secondly, the

13 For urban élites and public spending, see for example Richard Rodger, 'Managing the market - regulating the city: urban control in the nineteenth-century United Kingdom', in Herman Diederiks, Paul Hohenberg and Michael Wagenaar (eds), Economic Policy in Europe Since the Late Middle Ages: The Visible Hand and the Fortune of Cities (Leicester 1992), 200-19. For political controversies over plans to enlarge the port in Gothenburg, see Artur Attman, Göteborgs Stadsfullmäktige 1863-1962. 1: Göteborg 1863-1913 (Göteborg 1971), 275-7; idem, Göteborg 1863-1913, 349-52, 364-7.

14 Olsson, Från industristad till tjänstestad, 85-6; McEwen, 'Working-class politics in Gothenburg', 71-87. 289-311.

15 Göran Therborn argues that the Swedish bourgeoisie was born in Gothenburg between the years 1802-1816, see Göran Therborn, Borgarklass och byråkrati i Sverige: Anteckningar om en solskenshistoria (Lund 1989), 87-95. For the reputation as "the wealthy Gothenburg", see Fritz, Från handelstat till industristad, 182, and for party politics in the 1920s and 1930s, see Artur Attman, Stig Boberg and Arne Wåhlstrand, Göteborgs Stadsfullmäktige, 1863-1962. III: Stadsfullmäktige, stadens styrelser och förvaltningar (Göteborg 1971), 75-99. Sweden's reddest city - quote from McEwen, 'Working-class politics in Gothenburg', 180.

16 McEwen, 'Working-Class politics in Gothenburg', see in particular 362-3.
chapter opens opportunities to place health policy in the context of wider local politics and to discuss how health campaigns served to regulate cities and how these campaigns were contested.

The reason why this discussion was started with the images of Birmingham and Gothenburg was to highlight the controversial nature of many issues which are looked at in this chapter. While the size of the population or the number of rooms in a typical working-class house are relatively unproblematic 'facts' from the point of view of this study, the economic activity rate for women, the unemployment rate and the degree of social segregation are not. The concepts 'economically active', 'unemployed' and 'social segregation' were (and are) problematic, since they were politically charged and their meanings were unstable and open to re-definition. For example, official information about female economic contributions reflected and reinforced contemporary values concerning the family and women's role in society. Housewives were excluded from the category 'economically active' and even farmers and shopkeepers' wives, who engaged in productive labour in the narrow sense of the word, were usually defined as 'unoccupied'. This classification mirrored contemporary family values but it also provided a tacit justification for them. The exclusion of women's domestic and farm labour from the category of productive work made married women's economic dependence appear natural and justified. The count of the unemployed was (and is), as W. R. Garside has pointed out, "merely a count of those individuals who, according to the law and administrative practice of the time, felt it worthwhile to record themselves as out of work." As a general rule, the legislation and administrative practices were biased in favour of skilled male workers who were an important group politically. This continuity apart, practices varied widely according to economic and political trends and therefore comparing unemployment rates across national borders or over time in a single country is extremely problematic. Finally, contemporary studies of social segregation were strongly affected by writers' views about the nature of and reasons for urban inequality. These studies did not only describe spatial distribution of social classes but they also served to further either social integration or segregation.

SOCIAL CLASSES AND URBAN SPACE

At the beginning of the twentieth century, the City of Birmingham had a population of 522,000 and suburban areas outside the municipal boundaries contained a further 238,000 people, a large proportion of whom commuted to Birmingham every day. In 1911, when these surrounding districts were incorporated into the


city, Birmingham became England's largest provincial town with a population of 840,000, and around 1930 the city reached a population of one million.\textsuperscript{19} The expansion of municipal boundaries in 1911 was welcomed among others by the Medical Officer of Health (MOH), Dr. John Robertson, and the Chairman of the Housing Committee, John Nettlefold. They saw the reform, which "enabled the city to be spread over an area much larger than had ever been contemplated previously," as crucial for the future of the city and the well-being of its inhabitants.\textsuperscript{20} By increasing building land dramatically, the reform helped the city accommodate its growing population and expanding industries, but it also opened up opportunities to reorganize the urban space according to the principles of modern town planning. British garden suburbs such as Bournville in Birmingham and German town extension schemes, which the Birmingham Housing Committee had viewed during their visit to Germany in 1905, had convinced both Robertson and Nettlefold that town planning was the answer to many deep-rooted urban problems.\textsuperscript{21} They emphasized that building new suburbs \textit{per se} would not solve health and environmental problems in large cities. The mistakes of the past could be avoided only if the suburban growth and the redevelopment of the city centre were carefully planned and controlled. One of the most important aims of the planning process, Robertson argued, was to discourage mixed-use developments by creating zones some of which would be exclusively residential or recreational in character and the others devoted, for example, to industrial purposes.\textsuperscript{22}

An important, and not wholly unexpected, side-effect of the suburban extension and zoning was more widespread social segregation.\textsuperscript{23} Suburbanization, whether unregulated or planned, usually emerged from

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  \item \textsuperscript{20} \textit{Report of the Medical Officer of Health (MOH) on the Unhealthy Conditions in the Floodgate Street Area and Municipal Wards of St. Mary, St. Stephen and St. Bartholomew} (Health Department, Birmingham 1904), 21-3; \textit{Annual Report of the MOH for Birmingham} (hereafter \textit{Annual Report}) for 1906, 13. The quote is from 'Extract from the Annual Report of the MOH for Birmingham for 1918', in Janet E. Lane-Claypon, \textit{The Child Welfare Movement} (London 1920), Appendix VII, 304.
  
  \item \textsuperscript{21} Carl Chinn, \textit{Homes for People: 100 Years of Council Housing in Birmingham} (Exeter 1991), 22-4; M. J. Daunt, \textit{A Property-Owning Democracy? Housing in Britain} (London 1987), 50-2; John Nettlefold, \textit{Practical Town Planning} (London 1914), 134, 225. The Birmingham administrators had an active interest in German town planning. For example, Dr. H. W. Pooler, one of the delegates visiting Germany in 1905, argued that "we have much to learn from Germany as to wise and far-seeing planning, but have nothing to learn as to housing." H. W. Pooler, \textit{My Life in General Practice} (London 1948), 82. See also, Birmingham Public Record Office (BPRO), Public Health Committee (PHC), minutes 30. 1. 1925 item 8825. The delegates which Birmingham sent to Germany, Austria and Czechoslovakia in 1930 recommended that good English dwelling standards should be combined with European public amenities. Alison Ravetz, 'From working-class tenement to modern flat: local authorities and multi-storey housing between the wars', in Anthony Sutcliffe (ed.), \textit{Multi-Storey Living: The British Working-Class Experience} (London 1974), 133-4.
  
  \item \textsuperscript{22} John Nettlefold, \textit{Practical Housing} (Letchworth 1908); idem, \textit{Practical Town Planning; Report of the MOH on the Unhealthy Conditions}, 22-3; 'Extract from the Annual Report', in Lane-Claypon, \textit{The Child Welfare Movement}, Appendix VII; Chinn, \textit{Homes for People}, 22-4; Anthony Sutcliffe, \textit{Towards the Planned City: Germany, Britain, the United States and France 1780-1914} (Oxford 1981), 68-72; Cherry, \textit{Birmingham}, 93-4, 102-9.
  
  \item \textsuperscript{23} See also Savage and Warde, \textit{Urban Sociology}, 67.
\end{itemize}
and reinforced class and gender inequalities in cities. In nineteenth-century Britain, suburbs - or more precisely the interdependent relationship between suburbs and slums - had been an inextricable part of the growing economic and political power of the upper middle class. From the 1820s, Birmingham's merchants, manufacturers and professionals had celebrated their success and consolidated their power by moving from dense central areas to exclusive suburbs, where houses and streets were well-kept and neighbours respectable. Moreover, the rise of suburbia had not only gone hand in hand with the new status of the middle class but also with the new form of male-domination and the hegemony of the middle-class nuclear family. The separation of home and workplace had drastically limited job opportunities for married middle-class women, entrenching the division of labour within the family.24

The lower middle classes and the more prosperous sections of the working class followed in the wake of the manufacturers and merchants. These groups began to live away from Birmingham city centre in the late nineteenth and early twentieth centuries. New housing estates in outlying districts, though monotonous and lacking many public amenities, corresponded more closely with their aspirations than the core of the city with its ageing houses and polluting factories. In the first phase of this process, the Birmingham authorities did relatively little to encourage working-class suburban migration, confining themselves to providing new residential areas with basic urban infrastructure. In the early twentieth century, at the instigation of reformers such as Nettlefold and Robertson, the City Council reconsidered its stance and set itself to secure the continuation of suburban growth. The Council espoused a strategy which emphasized collaboration between the private and public sectors; new suburbs were planned by local authorities and built by private firms. However, this approach did not survive the housing crisis which deepened in the aftermath of the First World War. Prompted by the crisis the Unionist City Council, which had a history of antipathy to municipal housing provision, changed its policy and proceeded to build large Council estates, where thousands of working-class and lower middle-class families were to enjoy "the health-giving opportunities of the country."25 While focusing on new housing estates in outlying districts, the Birmingham authorities neglected the central wards. The policy of patching slums was condemned as unsatisfactory by the early 1920s, but very little was done during the inter-war years to redevelop the central wards.26 Old factories,


25 Quoted in: Nettlefold, Practical Housing, 5. See also, Chinn, Homes for People, 18, 22-6, 31-74; Cherry, Birmingham, 89-124; Helen Meller, Quality of the urban environment: responses to planning and urban change in Britain and France 1870-1945, in Susan Zimmermann (ed.), Urban Space and Identity in the European City 1890-1930s (Budapest 1995), 45-52; Rodger, Housing in Urban Britain, 56-7. For ideological continuities and discontinuities in the British housing policy, see Richard Rodger, 'Political economy, ideology and the persistence of working-class housing problems in Britain, 1850-1914', International Review of Social History 32 (1987), 109-43.

26 For discussion about slum patching, BPRO, PHC, minutes 9. 3. 1923 item 7421; 25. 5. 1923 item 7561.
workshops and warehouses and the poorest people, who were often represented as a pathological social underclass, remained in the central districts, while new industrial enterprises and 'respectable' working-class people left the urban core for the space and convenience of the fringes.27

Authorities were optimistic that suburbanization would indirectly alleviate living conditions in the slums. Providing the growth of the town population was slow, the people who remained in the central wards would benefit from the additional, better quality houses vacated by families who moved to new estates.28 In early twentieth-century Birmingham, conditions seemed to be favourable to this kind of 'filtering process'. Like many other large British cities, Birmingham had experienced its most rapid growth as early as the 1820s, when its population had increased by over 40 per cent within a decade (see Figure 2.1).29 After 1830 the

**Figure 2.1. Decennial population growth (%) in Birmingham and Gothenburg, 1800-1940**


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growth had gradually slackened, and between 1910 and 1930 the population increased only by 10 per cent in a decade. Furthermore, the growth in the 1910s, 1920s and 1930s was mainly due to natural increase, no longer to immigration. The influx of immigrants into Birmingham was slow in the interwar years, and during the depression in the early 1930s more people actually left the town than arrived. However, even in these favourable conditions, the effect of suburbanization on the living conditions in the slum areas was limited. Despite the operation of the filtering process, severe housing and environmental problems remained.

Gothenburg was a smaller city than Birmingham. Its population exceeded 100,000 in 1889 and 200,000 in 1919, reaching to 280,000 by 1940. The growth rate had been at its highest levels in the 1850s, 1870s and 1880s, exceeding 35 per cent in each decade (see Figure 2.1), and it was still round 25 per cent in the 1890s, although the extensive emigration to the United States served to retard urban growth. During the first two decades of the twentieth century, the decennial growth rate was about 20 per cent, being considerably higher than that in Birmingham. The post-war depression between 1920-1926, however, halted the flow of immigrants to Gothenburg and the growth rate decreased to eight per cent, increasing again to 15 per cent in the 1930s. The population growth in Gothenburg was due both to a natural increase and immigration, but these respectively varied considerably from year to year.

Spatial expressions of urban inequality were noticeable also in Gothenburg, but the relationship between social classes and urban space was clearly different from that in Birmingham. While in Birmingham the economic and political elite regulated the city from their protected enclaves outside the city centre, the Gothenburg upper middle class, a smaller and more closely knit group, consolidated its power by living in the centre or nearby areas. Furthermore, various reports, published in the late nineteenth and early twentieth centuries, give an impression that many municipal wards in Gothenburg had a fairly wide mix of social classes.

30 Growth data for the first two decades of the twentieth century include all the areas within the urban boundary. For Birmingham, see Sutcliffe and Smith, *History of Birmingham*, 9-10; Mitchell, *British Historical Statistics*, 26-7. For the decennial growth rate, see Sutcliffe and Smith, *History of Birmingham*, 9; Mitchell, *British Historical Statistics*, 26-7.


33 The flow of emigrants, which reached its peak in the 1880s and 1890s, remained substantial until up to the 1920s. Altogether 1.2 million people emigrated from Sweden to the United States and to some other countries in the years 1850-1914. Despite massive emigration, the rates of urban growth and general population growth were high in Sweden throughout this period. For the urban growth and population growth, see Lars Nilsson, *Den urbana transitionen: Tätorterna i svensk samhällsomvandling 1800-1980* (Stockholm 1989), 182-93, 248; Erland Hofsten, *Svensk befolkningshistoria: Några grunddrag i utvecklingen från 1750* (Stockholm 1986); *Historisk statistik för Sverige. Del 1*, 61-6; Attman, *Göteborg 1913-1962*, 199. For emigration, see *Historisk statistik för Sverige. I: Befolkningsvuxenhet*: *Statistik årsbok för Göteborg* 1955, tables B 16, 17 and 18; Attman, *Göteborg 1863-1913*, 72-6; Ann-Sofie Kalvemark (ed.), *Utvandringen: Den svenska emigrationen till Amerika i historisk perspektiv* (Stockholm 1973); Agneta Hermansson, 'Från Packhuskajen till Amerika', in Lili Kaelas and Kristina Söderpalm (eds), *För hundra år sedan - skildringar från Göteborgs 1880-tal* (Göteborg 1984), 209-27.

34 For example, Björn Wallqvist, *Bostadsförhållandena för de mindre bemedlade i Göteborg*: *Studie sommaren 1889* (Stockholm 1891), 3-11; Carl Lindman, *Sundhets- och befolkningsförhållanden i Sveriges städer 1851-1909: I* (Hälsingborg 1911), 66-95. See also, Marjaana Niemi, 'Making the unknown known: town and townspeople in
Birmingham. The death rates for wards in Gothenburg varied from 13 to 19 per 1,000 population in the 1890s, whereas in Birmingham they ranged between 14 and 29.\(^3\)\(^5\) Residential segregation appeared to develop slowly in Gothenburg and, in consequence, the poor and the well-to-do still lived relatively close to each other at the turn of the century. For example, a considerable number of poor people were dispersed throughout some prosperous central areas. Most of these people occupied cheap flats and houses which were tucked away in courtyards and narrow back streets, but some of them lived literally under the same roof as the more wealthier citizens - in attics, basements and cellars. However, the trend was clearly towards more widespread segregation, even though the middle-class suburban migration did not began in earnest until the 1950s and 1960s. Despite the new health services that aimed to improve the health of the working class, the gap between the healthy and unhealthy wards in Gothenburg, as in Birmingham, remained wide in the first decades of the twentieth century. In the 1920s, the death rates for wards in Gothenburg varied usually from 7 to 13 and in Birmingham from 8 to 17 per 1000 population.\(^3\)\(^6\)

In discussing the spatial arrangements in these two cities, it is important to bear in mind that Gothenburg had not grown 'spontaneously'. It had been founded by the Crown and built according to a town plan produced by a Dutch engineer in the early 1620s. The street system which he designed for the centre of the city remains basically unchanged even today with the exception of a few enclosed canals. This original town plan was revised and extended in 1808, when the fortifications were dismantled, and again in the 1860s, in the midst of rapid population growth (See Figure 2.1). A new plan for the eastern and southern districts of the city was accepted in 1907. However, planning authorities were not always able to keep up with the expansion of the city and therefore a significant proportion of urban growth in Gothenburg, and in many other Swedish towns, took place outside the planned areas. This caused problems, since the districts where building ordinances imposed no restrictions on house building inevitably attracted the poorest people. A desire to prevent the development of unhealthy and insanitary shanty towns in outlying areas was one of the moving forces behind Swedish town planning until the early twentieth century. Other important aims were to achieve the greatest possible protection against fire and to secure smooth flow of traffic and a reasonable standard of hygiene throughout the city.\(^3\)\(^7\)

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\(^3\)\(^5\) For death rates in wards, see Goteborgs halsovardsnämnds årsbetättelse (hereafter Årsbetättelse) for 1892, 46; for 1898, table 18; Annual Report for 1897, 8-9; for 1898, 8-9; for 1899, 7.


The City Architect for Gothenburg, Albert Lilienberg, who was the leading advocate of modern town planning in Sweden in the 1910s and 1920s, imported some ideas from the British garden city movement into Swedish planning. However, the way in which these ideas were implemented in Gothenburg and in Sweden in general was different from that in Britain. Swedish planners and social reformers may have been inspired by the same anti-urbanism that permeated the British town planning movement but most speculators and municipal authorities in large Swedish cities were in favour of more efficient exploitation of the building land. Hence many new residential areas were predominated by relatively high and densely grouped buildings. Rural idyll and urban sophistication intertwined in garden suburbs such as Landala in Gothenburg and Enskede in Stockholm, but this type of well-designed areas were often occupied by middle-class people. The Gothenburg authorities were also interested in zoning, but did not regard it as a matter of urgency, since houses and factories did not intermingle in Gothenburg in the way they did in Birmingham. In general, the Swedish and Nordic planning was influenced more by German and Austrian town planning and by the works of planners such as Camillo Sitte than by British reformers Ebenezer Howard and Raymond Unwin.

--- TENEMENT BLOCKS AND BACK-TO-BACK HOUSES ---

Many working-class areas in Gothenburg were dominated by wooden, three-storey tenements (landshödlingehus) which were divided into small flats, each normally one room and a kitchen, sometimes two rooms and a kitchen. Although the vast majority of working-class people lived in small tenement flats, the housing market in working-class areas was by no means undifferentiated. The standard of housing available for different groups varied greatly according to income. Annedal, which was inhabited by "the elite of the working class" and lower middle-class people such as shopkeepers, primary school teachers and policemen, was a model quarter of the town at the turn of the century. In the eyes of many contemporaries, this area was an example of what could be done by careful planning. Tenement buildings and other houses were structurally sound and carefully designed, flower beds were well-arranged and public buildings such as schools reflected civic pride. In Masthuggsbergen, Kvarnberget and Otterhallorna, by contrast, most inhabitants lived in insanitary, badly-built houses, and the poorest of them occupied dilapidated cellars and attics.

38 For the impact of garden city ideas on Nordic planning see Thomas Hall, 'Concluding remarks: is there a Nordic planning tradition?', in Hall (ed.), Planning and Urban Growth, 248-9; idem, 'Urban planning in Sweden'; Mats Deland, 'Garden suburbs as disciplining of space. The Swedish experience around 1900', in Clemens Zimmermann (ed.), Europäische Wohnungs- und Wohnungspolitik in vergleichender Perspektive 1900-1939/ European Housing Policy in Comparative Perspective 1900-1939 (Stuttgart 1997), 16-41; Laura Kolbe, Kulosaari - Unelma paremmasta tulevaisuudesta (Helsinki 1988); 'Finland - general section', and Harald Andersin, 'Finland', in Hegemann (ed.), International Cities, 85-91.


40 Wallqvist, Bostadsförhållanden, 3-11; Gudrun Lönnroth, 'Stadsbilden - praktfulla palats och usla kåkfar', and Enmark, 'Bo och leva i Annedal', in Kaelas and Soderpalm (eds), För hundra år sedan, 22-62 and 141-57; Gun
Overcrowding remained a critical aspect of the housing problem in Gothenburg throughout the period reviewed here. If the contemporary definition of overcrowding, more than two persons per room, is used to assess the problem, about 38 per cent of Gothenburg's population lived in overcrowded accommodation in 1910. Of those inhabitants who occupied apartments with less than 5 rooms, almost half lived more than two persons per a room.\(^41\) Owing to the lack of space within the home, Swedish working-class families were not able to live up to the same standards of 'decency' and 'propriety' that large sections of the English working class imposed themselves. The small number of rooms per tenement flat prevented any great specialization in the use of rooms, and it was often difficult, if not impossible, to ensure privacy between parents and children, between sons and daughters and between daughters and male lodgers.\(^42\) Moreover, rents were high in both Gothenburg and Stockholm. In 1914, a 'normal' working-class household in Stockholm spent about 27 per cent of their income on rent. A government commission, which published its report in 1914, highlighted the seriousness of the housing problem by suggesting that the Swedes might have the worst and most expensive houses in industrial Europe.\(^43\) This view was probably too pessimistic. The standard of housing in Swedish cities was appreciably below that of Birmingham and other English cities, but it was comparable with or even better than the standard of housing in Scottish cities.\(^44\)

Speculative builders were the most active providers of new housing in Gothenburg in the late nineteenth and early twentieth centuries, but working-class houses were also built on a non-speculative basis. Some employers provided houses for their own workers in order to attract and retain skilled labour, while various philanthropic and co-operative associations built houses to improve the health and morals of the working class. The Gothenburg City Council, by contrast, maintained its faith in the private housing market until well into the 1910s, restricting its activities to the provision of cheap building land for co-operative and philanthropic associations. In 1915, however, the municipal policy-makers shifted from their earlier attitudes...
and decided in favour of building municipal housing, and in the 1920s and 1930s, when the Social Democratic Party was the largest group in the City Council, the public efforts to ease housing shortage and improve housing conditions were intensified.\textsuperscript{45} Pushing through housing and slum clearance schemes was often a delicate balancing act, since all expensive municipal projects required a two-thirds majority in the City Council. The Social Democrats had to win, in addition to Communist support, some Liberal or Conservative backing.\textsuperscript{46}

During the most difficult housing crises the Conservatives and Liberals were ready to accept municipal intervention in the housing market, but in general most of them favoured non-interventionist policies. Despite this opposition the Social Democrats often managed to achieve the necessary two-thirds majority. By 1934 the Gothenburg corporation had built 2,700 flats for the rental sector and 674 houses and flats for owner-occupiers. Furthermore, the corporation had helped finance 2,400 flats and houses which were built by housing associations. Compared to Stockholm, Gothenburg had a substantial involvement in municipal housing, but on the other hand the financial support it provided for housing associations was rather modest.\textsuperscript{47}

From the point of view of this study, two aspects of Gothenburg's municipal housing policy are particularly important. Firstly, the corporation did not usually provide improved accommodation for those in most housing need. Although many municipal tenements were initially meant for people dispossessed from the slums, in practice these houses were usually occupied by relatively affluent working-class families. Secondly, local authority provision only made small inroads into the problem of overcrowding, since a large proportion of municipal housing consisted of two-roomed flats. In 1920, about 62 per cent of the housing stock in Gothenburg had only one or two rooms, and in 1939 54 per cent of houses still belonged to this category. However, the standards of amenities in the houses improved considerably. For example, the percentage of flats and houses which had central heating rose from 8 to 61 during the period 1920-1939.\textsuperscript{48}

In Gothenburg, where many affluent middle-class families lived in flats, people did not observe social barriers between different house types. In Birmingham, by contrast, tenement flats were invariably associated with the poorest strata of society and low standards of accommodation. Nineteenth-century Birmingham had managed to accommodate its working-class population in small, self-contained houses, either in back-to-back court dwellings or by-law terraced houses, and early twentieth-century Birmingham was determined to continue the tradition and discourage flat-building. Proposals to build subsidized multi-


\textsuperscript{46} McEwen, 'Working-class politics in Gothenburg', 99, 185-8.


storey flats were put forward time and again in municipal politics but, as Anthony Sutcliffe has pointed out, "a strong middle-class distrust and a working-class dislike of flats" served to postpone extensive flat-building projects until the mid-1930s. For example in 1925, the MOH and a number of working-class organizations joined their forces to defeat the scheme to erect tenement buildings.

In general, housing provision was better and more plentiful in Birmingham than in Gothenburg. In Birmingham only 2 per cent of housing was of one and two roomed houses in 1910, whereas the corresponding figure for Gothenburg was 62. Owing to the predominance of self-contained houses with three or more rooms, only 10 per cent of residents in Birmingham lived more than two persons per room, a degree of overcrowding which was a quarter of that in Gothenburg. Consequently, overcrowding as such was not the most pressing issue in Birmingham in the early years of the twentieth century. Instead, health authorities' attention was occupied by the question of how to maintain reasonable housing standards in the city centre which was growing old. The large proportion of houses in the central wards were old, deteriorating back-to-back houses which usually comprised three rooms built one upon another: a living-room, a bedroom and an attic. Each house joined to another house at the back and often also both sides so that the only door and all windows were on the front wall. Double rows of these houses were built near each other and courts were closed at both ends by communal privies or by another row of houses.

In the early nineteenth century back-to-back housing had provided a convenient solution to the persistent housing shortage of the rapidly expanding city. However, in the 1840s, when these houses constituted about 60-70 per cent of the total housing stock in Birmingham and in many other Midlands and South Lancashire towns, social reformers took them as an object of their criticism. High-density back-to-backs and intimate courtyards, which were hidden from the general gaze and protected from the regulation of outsiders, were criticized for being detrimental to the health and morals of their inhabitants. Prompted by these debates, Manchester and Nottingham introduced by-laws which forbade the building of back-to-backs in the 1840s, while Birmingham, which was notorious for its inactivity in public health questions in the mid-nineteenth century, did not consider this measure necessary. New back-to-backs continued to be built in Birmingham until 1870s, when the City Council passed a by-law that required houses to have both front and back entrances and open space on two sides. The MOH for Birmingham, Dr. Alfred Hill, argued in 1873 that

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49 Anthony Sutcliffe, 'Introduction', and idem, 'A century of flats in Birmingham 1875-1973', in Sutcliffe (ed.), Multi-Storey Living, 1-18, 181-206, the quote 182; Mayne, The Imagined Slum, 84-5, 90; Chinn, Homes for People.

50 BPRO, PHC, minutes 30. 1. 1925 item 8825; 27. 2. 1925 item 8901. See also Chapter 6.


52 Burnett, A Social History of Housing, 166-7; Chinn, Homes for People, 1-8; Rodger, Housing in Urban Britain, 32-4. See also the autobiography of Kathleen Dayus, Her People (London 1982), 3.

53 Bill Bramwell, 'Public space and local communities: the example of Birmingham, 1840-80', in Gerry Kearns and Charles W. J. Withers (eds), Urbanising Britain: Essays on Class and Community in the Nineteenth Century (Cambridge
back-to-back houses were the major culprit in keeping death rates high in the central wards of the city. In his opinion, the principal reason why these houses were so detrimental to health was that through ventilation was impossible. It had been, he wrote, a "very common practice in Birmingham to erect houses in rows back to back and in some cases this peculiarity of disposition is apparently necessary in order to prevent their falling or being blown down, so flimsily are they built; but such a mode of construction prevents what is of immense importance - a through dra ft."54 Another great disadvantage lay in the sanitary provision of these houses. Bad drainage and sewage, irregularly cleaned communal privies, shared water taps which drew impure water from underground wells and unpaved yards which were sodden with filth made courtyard houses an ideal breeding ground for diseases.

Despite the fierce criticism, there were still 42,000 back-to-backs in Birmingham on the eve of the First World War and no serious attempt was made to replace them for a long time. In 1919, The British Medical Journal stated that the victory over Germany in the war seemed to have made decision-makers blind to enormous domestic problems, one of which was the housing crisis in cities such as Birmingham: "We, too, may add as a refrain to the speeches of our strong men in praise of our national exertions and prophesying a new heaven and earth, this sentence: In the city of Birmingham 200,000 persons live in back-to-back houses."55 The decision-makers were not blind to the housing crisis, far from it, but back-to-back houses were no longer regarded as the core of the problem in the aftermath of the First World War. The housing shortage had been aggravated during the war, so that even many lower middle-class families were having difficulty finding decent housing. In this new situation, addressing the housing problems of the poorest strata became a less pressing need and attention shifted away from the urban core to the fringe, where new houses were being built for respectable lower middle-class and working-class families. In the interwar years, Birmingham built about 50,000 council houses, more than any other local authority in England. Nearly 39,000 back-to-backs, which still remained in the central wards in 1936, were occupied by the poorest section of the population, who could not afford to rent a council house.56

Housing conditions in working-class suburbs varied enormously. At one end of the housing spectrum was Bournville, a garden suburb which the Cadbury family had created by converting Ebenezer Howard's ideas into brick and mortar. In Bournville, respectable working-class families lived in well-built and spacious houses which had a front and rear garden and were well provided with facilities. Furthermore, the estate as a

1991), 36-9; Chinn, Homes for People, 1-30; Sutcliffe, 'A century of flats in Birmingham 1875-1973'; Rodger, Housing in Urban Britain, 32-4; Burnett, A Social History of Housing, 70-7; Cherry, Birmingham, 66-73.

54 Annual Report for 1873, 19; for 1898, 8-15, 34-9.

55 'The Housing Question' The British Medical Journal (1919), 574.

whole was carefully planned: "Nothing has been allowed to obstruct the free circulation of air and a maximum of sunshine."57 Similar principles were followed in municipal house building in the 1920s. With the generous support of central government, Birmingham built high quality garden suburbs to house the 'decent' working class. At another end of the housing scale were, for example, old shabby suburbs which private developers had built in the late nineteenth century and new municipal estates which were built for the poor in the 1930s. Space and amenity standards were considerably lower in these areas than in garden suburbs.58 Although suburban houses were better-built and equipped than the back-to-backs, they did not seem to promote health as much as authorities expected. A study by G. MacGonigle and J. Kirby, which was published in 1937, indicated strongly that environmental improvement alone did not promote health. Many poor families who grasped new opportunities in the suburbs spent a large proportion of their incomes on rent and consequently suffered from malnutrition. MacGonigle and Kirby concluded that adequate nutrition rather than environmental improvements were crucial in improving public health.59

--- ECONOMY AND EMPLOYMENT ---

During the late nineteenth and early twentieth centuries, Gothenburg evolved from a city of merchants to one of the nation's leading industrial centres. Mercantile enterprises, which had been the moving force in the local economy for decades, closed down one after another, unable to respond to changing market conditions. Commercial banks replaced them as the main source of capital for financing new ventures, and local industries, which had grown large enough to sell their products themselves, cut out the middleman.60 The growth of industry had accelerated in the 1890s. Textile firms, sugar and tobacco factories and breweries, many of which had been established before the 1850s, were the first to seize new opportunities, and wood-working and paper-making industries soon followed their example. All these sectors expanded rapidly in the 1890s. In the first decade of the twentieth century, new manufacturing concerns were established in shipbuilding and engineering, and these helped to diversify the industrial base of the city, although their position was still modest compared with that of the leading sectors. Textiles and clothing remained Gothenburg's most important industries, accounting for one-third of all industrial employment. However,


58 Chinn, Homes for People.


60 Fritz, Från handelsstad till industristad, 71-6, 266-7; Attman, Göteborg 1863-1913, 6; McEwen, 'Working-class politics in Gothenburg,' 74-5.
their dominance came to an end in the 1910s, when there was an unprecedented employment surge in metal industry. In the course of the next ten years, the metal industry increased its share of industrial workers from 17 per cent to 36, and in 1930 no less than 43 per cent of workers were employed by metal and engineering firms, the most important of which were two shipyards, Götaverken and Eriksberg, and a ball bearing manufacturer, Svenska Kullagerfabriken (SKF), which became a world-wide concern in the 1920s.61

Owing to the dominance of export industries such as engineering and shipbuilding, the local economy was acutely affected by dislocations in international trade. This problem was especially serious during the worldwide recession in the early 1920s, when the metal firm SKF had not yet consolidated its position in the world market. The reduction in metal employment was such that at one point during the winter 1921-22 almost 70 per cent of unionized metal workers in Gothenburg were unemployed. A decade later, in 1932, the unemployment rate among metal workers was again high, at 35 per cent. The recessions aside, metal employment in Gothenburg was basically regular and mainly skilled or semi-skilled. Textile and food processing industries, which served the domestic market, offered a good prospect of job security, and Gothenburg was also able to attract new industries. Vital for the future of the city was the establishment of the Volvo car plant in 1927. All in all, the interwar years were a period of expansion for Gothenburg which was reflected, for example, in the growing demand for health services and housing.62

While Gothenburg's economy was affected by dislocations in the world market, Birmingham's economic life was less sensitive to tendencies in the international trade and more capable of adapting to changing circumstances. Birmingham's economy had been built upon industrial production since the late eighteenth century and in this respect the late nineteenth and early twentieth centuries did not bring any fundamental changes.63 Industry was undergoing structural transformations, but even these processes were marked by continuities. Firstly, workshops and small factories had an important part in Birmingham's industrial life throughout the period covered here, although the trend clearly was from labour-intensive, small-scale production to mechanised mass-production. Secondly, industrial diversity persisted. While some old industries such as jewellery were clearly on the decline, the others continued to play a major role in the economic life of the city. The metalworking and engineering sectors managed to retain their place among

61 Fritz, Från handelsstad till industristad; Olsson, Från industristad till tjänstestad; Attman, Göteborg 1863-1913; idem, Göteborg 1913-1962. For the dominance of textile industry in the nineteenth century, see Atman, Göteborg 1863-1913, 31-42, 96-115; Åberg, En fråga om klass?, 41-4; Artur Attman, 'Näringsliv och samhälle', in Kaelas and Soderpalm (eds), För hundra år sedan, 17-23.


key industries by modernizing their production. Instead of simple or semi-finished metal articles, early
twentieth-century metal firms produced technically sophisticated, finished products. Alongside these old
industries, there were new sectors such as the cycle manufacture, electrical trades and car industry. By 1951
the vehicle industry, which had expanded throughout the first half of the twentieth century, outstripped its
rivals and became the leading manufacturing sector in Birmingham in terms of the labour force.64 Owing to
the broad base of industrial production, Birmingham avoided the worst effects of the recessions and
recovered more rapidly than industrial towns in Northern England (Figure 2.2), Scotland and Wales.65

Figure 2.2. Percentage of insured workers unemployed
in Liverpool, Manchester and Birmingham*,
December 1929 - July 1934

* The Birmingham figures include men from depressed areas who were attending government training or instructional
centres.

Source: Local Unemployment Index. Statistics of Unemployment, prepared by the Ministry of Labour. (H.M.S.O),
Numbers 48-91.

The decades from 1870 to 1910 were a period of increasing gender segregation in Birmingham trades. By
1911 the horizontal and vertical dividing lines between men's and women's occupations were very clear.
Workers employed in building and transport sectors or in gas and electricity plants were almost exclusively
men, whereas laundry workers, dress and shirt makers and seamstresses were women. Jewellery, car and
cycle manufacture and metal industry employed both men and women, but in these sectors women almost

64 Census of England and Wales 1911. Vol. X: Occupations and Industries. Part II, Table 13, 593-5; Census of
England and Wales 1951. Industry Tables, Table 2, 92-4; Sutcliffe and Smith, Birmingham 1939-1970, 154-64.

65 For the economic and industrial life of Birmingham, see Briggs, History of Birmingham, 28-31,43-66, 278-301;
Sutcliffe and Smith, Birmingham 1939-1970, 6-9; Barbara M. D. Smith, 'Industry and trade 1880-1960', in A History of
the County of Warwick. Volume VII: The City of Birmingham (London 1964), 171-8, 190-208; Cherry, Birmingham, 60-
6; Berg, The Age of Manufactures, 264-9, 274-9. For Birmingham's economy in a national context, see John Stevenson,
British Society 1914-45 (London 1984), 106-16, 267-74; Sidney Pollard, The Development of the British Economy 1914-
INDUSTRIAL CITIES

invariably found themselves working in lower grade jobs than men. For example, iron founding, brass founding and tool making were male dominated jobs, whereas needle, pin and steel-pen making were predominantly female occupations. Irrespective of whether they worked in a female dominated sector or not, women workers usually earned less than half the average weekly earnings of men. In Birmingham factories, the average earnings of married women workers, most of whom had to partially maintain their families, was only 9/1d per week at the beginning of the twentieth century, while unskilled male labourers received between 17/- and 21/-.

Adult women employed in the city's cycle industry earned 10/6d. In 1914, women who were "really first-class workers" or "exceptionally good machine rulers" were able to earn 20/-. In Britain in general, women working in metal industry earned only 38 per cent of male earnings in 1906 and 46 per cent in 1935. In textile industry, women's pay was about 55 per cent of men's pay throughout the period reviewed here.

In Birmingham a significant number of married women were employed as homeworkers or outworkers in the early years of the twentieth century. The commonest tasks which female homeworkers undertook were the carding of hooks and eyes, sewing of buttons on to cards and wrapping up hair pins in paper, but a large number of women worked also in jewellery and metal trades like metal burnishing and plating. While metal burnishing was relatively well paid, much of the other work which women homeworkers did amounted to sweating. The jobs were tiring and repetitive, and the wages were below the subsistence level. Furthermore, homeworkers often worked in insanitary conditions which made them susceptible to ill-health and in particular to tuberculosis. To what extent women engaged in this type of work is difficult to estimate, since Census enumerators systematically failed to record married women's part time work.

Attitudes to married women's work were generally negative in Britain during the first half of the twentieth century. The central and local government, the press, employers and trade unions were all committed to reinforce the male-breadwinner family model. These attitudes manifested themselves, for example, in legislative restrictions such as the marriage bar which inhibited women's activity rates and ensured that men


68 Chinn, Homes for People, 19; Smith, 'Industry and Trade'; Lewis, Women in England, 58-62. For the working conditions of women homeworkers and outworkers, see also Gertrude M. Tuckwell, The regulation of women's work', in Gertrude M. Tuckwell et al., Woman in Industry: From Seven Points of View (London 1908), 1-23.


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had priority in the labour market. Women pursuing professional careers were almost invariably forced to give up their work upon marriage, but a marriage bar was also applied to many other women workers. The Birmingham Public Health Department demanded not only women doctors but also health visitors and nurses to renounce their work once they got married. Moreover, many British companies which employed working-class women, for example Boots and Unilever, operated marriage bars in the interwar years. Unsurprisingly, women had mixed feelings about measures which served to curtail their job opportunities. For example, the Labour women, who generally endorsed the male bread-winner family model, joined middle-class feminists in defending women's right to work and in opposing drastic measures such as the marriage bar which circumscribed this right.

In Gothenburg, the labour market was characterized by a high degree of horizontal gender segregation. The old industries, textile and food processing, were concerned to employ female labour, and at the turn of the century, when these sectors still predominated, women comprised almost 50 per cent of all industrial workers in Gothenburg. However, their proportion in the total industrial workforce was to decline in the early years of the twentieth century, when metal and engineering industries started expanding. With the exception of the ball bearing manufacturer SKF, which had a significant number of women on its payroll, metalworking and engineering firms employed almost exclusively men. Hence by 1913 the proportion of women in the total industrial workforce had declined from 47 per cent to 34 per cent and continued to fall, albeit slowly, during the interwar years. In 1929, women comprised 29 per cent of the industrial workers and the vast majority of them were employed in textile and food processing industries. Outside the industrial

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71 For a Birmingham campaign against the marriage bar, see BPRO, M&CWC 26. 9. 1930 item 365, 9. 1. 1931 item 499, 23. 1. 1931 item 514. See also, Pat Thane, 'Visions of gender in the making of the British welfare state: the case of women in the British Labour Party and social policy, 1906-1945', in Gisela Bock and Pat Thane (eds), Maternity and Gender Policies: Women and the Rise of the European Welfare States 1880s-1950s (London 1991), 98-9; Jane Lewis and Sonya O. Rose, "Let England blush:" protective labor legislation, 1820-1914'; in Ulla Wikander, Alice Kessler-Harris and Jane Lewis (eds), Protecting Women: Labor Legislation in Europe, the United States, and Australia, 1880-1920 (Urbana 1995), 91-124 and in particular 109-10; Lewis, Women in England, 34. However, in some occupations, single women demanded the banning of married women, and most women across the political spectrum were in favour of protective labour legislation for women, see Joanna Bourke, Working-Class Cultures in Britain 1890-1960: Gender, Class and Ethnicity (London 1994), 104; Lewis "Let England Blush".

72 In 1895, Gothenburg's manufacturing sector provided jobs for 3353 women (47 %) and 3827 (53 %) men. The proportion of women in the industrial workforce was higher in Gothenburg than, for example, in Stockholm and Malmö. Bidrag till Sveriges Officiella Statistik (BISOS) 1895, D) Fabriker och Manufacturer, Table 7; Carl Lindman, Dödligheten i första lefnadsåret i Sveriges tjugo större städer 1876-95 (Stockholm 1898), 91. For sex typing of jobs in Sweden, see for example Lena Sommestad, Gendering work, interpreting gender: the masculinization of dairy work in Sweden, 1850-1950, History Workshop, issue 37 (1994), 57-76; Ulla Wikander, 'Periodization and the engendering of technology: the pottery of Gustavsberg, Sweden, 1880-1980', in Gertjan de Groot and Marlou Schrover (eds), Women Workers and Technological Change in Europe in the Nineteenth and Twentieth Centuries (London 1995), 135-50.

73 Olsson, Lönepolitik och lönestruktur, 113-9.

74 Statistisk årsbok för Göteborg 1921, 174-84, table 159; 1930, 135-40, table 148.
sector, domestic service fell into decline, while the expanding service sector generated new employment opportunities for women of all classes.\textsuperscript{75}

In Gothenburg wage differentials between women and men, though not as wide as in Birmingham, were substantial. For example, in tobacco factories women usually received lower pay although they performed exactly the same tasks as men. Only 15 per cent of skilled female cigar makers earned more than 800 crowns a year in the late nineteenth century, whereas the corresponding figure for men was 50. However, compared to other female workers and even to some male workers, skilled female cigar makers earned high wages and had good terms of employment. This small group of women was also exceptionally active in the trade union and a large proportion of them stayed in the factory after marriage. Women who were employed in metal industry had also relatively high wages. The ball bearing firm SKF paid women about 60-65 per cent of the average wage of male employees in the 1920s, and 80-85 per cent in the 1930s. On the other hand, a survey of 3,000 female factory workers, conducted in Stockholm in the 1890s, showed that 38 per cent of them earned less than 365 crowns a year and therefore were below the basic level of subsistence. Domestic servants were often paid 180-240 crowns a year with board and lodging.\textsuperscript{76}

In Gothenburg married women's work did not raise the same degree of resentment as in Birmingham. The male bread-winner ideology was relatively weak in Sweden and women, both unmarried and married, were often seen as a permanent part of the workforce, not just as a labour reserve. The weakness of the male-breadwinner family model, as Lena Sommestad has pointed out, had its historical roots in emigration and financial stringency. Owing to the shortage of labour, Swedish society needed women's labour power, and many Swedish working-class families would not have survived without women's earnings, since per capita income was low.\textsuperscript{77} The difference between Gothenburg and Birmingham in attitudes to women's work manifests itself, for example, in reactions to female unemployment. While in Birmingham female unemployment was never conceptualized as a problem, the Gothenburg authorities organized a special course for unemployed textile workers as early as 1918. The aim was to provide unemployed women with an opportunity to develop their skills, but policy-makers may have also been motivated by a fear that some unemployed young women, if not occupied with useful tasks, would move to prostitution.\textsuperscript{78} Furthermore,


\textsuperscript{77} Sommestad, 'Welfare state attitudes'; Lewis, 'Gender and the development of welfare regimes'.

\textsuperscript{78} Göteborgs Stadsfullmäktiges Handlingar 1918:24.
Swedish legislators were rather reluctant to introduce restrictions which would have inhibited women's activity rates. In 1909, Sweden followed the example set by other European countries, prohibiting women's night work in industry, although women across the political spectrum were against this measure. Attempts to introduce more drastic measures such as the marriage bar were not successful. On the contrary, the Swedish parliament passed in 1939 a law which prohibited employees from being fired on account of marriage, pregnancy or childbearing.

Despite the difference in attitudes, the majority of working-class women in both Birmingham and Gothenburg gave up formal paid employment after getting married, or at least after the first child was born, and only rarely did they re-enter labour force at a later stage. Diverse household tasks and child-rearing occupied most of their time but, if family circumstances required, they augmented the family income by engaging in casual, seasonal or part time work such as charring, washing, sewing, baby-sitting or lodging-house keeping. As a result of rising real wages a growing number of working-class men were able to provide for their families and therefore their wives devoted more of their time to housewifery. In Gothenburg, his trend found its reflection in the pages of the local Social Democratic newspaper Ny Tid. While in the early twentieth century the paper had concentrated almost exclusively on local and national politics or on trade union questions, in the 1920s it introduced women's pages, where articles and stories centred around household management, childrearing, cookery, gardening and fashion.

It is difficult to estimate the extent to which women who had young children participated in the workforce. In Gothenburg, almost 10 per cent of married women with young children were 'gainfully employed' in the 1920s, but there was also a significant number of unmarried women with dependent children who worked outside the home. In Birmingham, the census 1911 categorised 18 per cent of married women as 'gainfully employed', but does not provide any information about how many of them had young children. In case of married women, the main reason for combining work and motherhood was poverty resulting from low pay,
unemployment or disability of a male breadwinner. Despite health and unemployment insurance and relief works, long-term illness or unemployment on the part of the husband often plunged a family into poverty and left the wife little option but to work full-time outside the home.85

--- THE FAMILY ---

In Gothenburg and in Sweden in general, marriage and family patterns varied widely depending on the social group. Among the urban middle class, marriage formation and pre-marital relations were strictly controlled and in consequence the percentage of illegitimate children was very low. Working-class people in towns and un-propertied people in the countryside, by contrast, had relatively tolerant attitude to pre-marital relations and even to pre-marital co-habitation. Despite public efforts to encourage more orthodox marriage and family patterns, the illegitimate birth rate remained high in Sweden throughout the period covered here. In Stockholm the proportion of illegitimate children had traditionally been very high - almost 50 per cent in the mid-nineteenth century - and in the early twentieth century it was still considerably higher than in other Swedish cities. In Gothenburg, the percentage of illegitimate children among all newborn babies hovered around 20 per cent from the turn of the century until the 1930s, when it started declining.86 However, many illegitimate children were born into relationships similar to marriage and their parents often got married after the child was born, legalizing their long-standing relationship. Furthermore, a large proportion of unmarried mothers married someone other than the father of their child. Yet there were a considerable number of women, single mothers, widows and deserted wives, in Swedish cities who maintained their children entirely by themselves. At the turn of the century a survey conducted in Stockholm showed that a third of women who had children were solely responsible for them.87

84 Wallentin, Arbetslöshet och levnadsförhållanden, 30-1.

85 Rafael Lindqvist, Från folkrörelse till väljärdsbyråkrati: Det svenska sjukförsäkringsystemets utveckling 1900-1990 (Lund 1990), 56-77; Margaret Weir and Theda Skocpol, 'State structures and the possibilities for "Keynesian" responses to the Great Depression in Sweden, Britain, and the United States', in Peter B. Evans, Dietrich Rueschemeyer and Theda Skocpol (eds), Bringing the State Back In (Cambridge 1985), 120-32; Lewis, Women in England, 45-74.

86 Statistisk årsbok för Göteborg 1924, 52, table 33; 1930, 36, table 29; 1934, 28, table 26; 1939, 28, table 26.

In early twentieth-century Britain, marriage and family patterns were much more uniform and attitudes to pre-marital relations and in particular to unmarried motherhood less tolerant. The view that 'the family' consisted of a married couple and children was clearly accepted not only throughout the middle classes but also through much of the working class. Illegitimacy rates were at between 4 and 5 per cent until the First World War, when they rose sharply, and then immediately after the war they fell back again. In Birmingham, as in many other large British cities, the rates were even lower, around 3 per cent (See Figure 2.3.) and unmarried mothers were a small minority. One reason why illegitimacy rates remained so low was that a large proportion, about 70 per cent, of premarital conceptions were legitimized by marriage before the birth.

The treatment of unmarried pregnant women and mothers was often punitive. They were singled out as a social problem partly because of the expenditure they imposed on the community and partly because unmarried motherhood posed a moral threat to the stability of the conventional family. Furthermore, immorality and illegitimacy, as Mathew Thomson has pointed out, were so closely linked with mental defects that immorality was often viewed as evidence of mental defect. This linkage provided a powerful justification to place not only prostitutes but also unmarried mothers under protection and control in rescue

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homes. The strong stigma of illegitimacy which was placed both on the mother and her child, the harshness of bastardy laws, and women's low earnings ensured that unmarried mothers and their children were one of the most vulnerable groups in society. Since family patterns and attitudes to one-parent families were different in Britain and Sweden, it is interesting to examine how health authorities in Birmingham and Gothenburg sought to regulate family life and, perhaps more importantly, how they proved that the policy they pursued was scientific and rational. The approach which they chose depended, to an extent, on public health traditions and pre-existing institutional arrangements which are discussed in the next chapter.

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POLICY LEGACIES

"We are still the children of the liberal reformers, patching the mechanisms haphazardly bequeathed to postwar societies proud of their supposed uniqueness."

Hugo Heclo, Modern Social Politics in Britain and Sweden (1974)

Policy-making is inherently a historical process. Previously established policies generally influence present-day decision-making which in turn shapes future policy options. In constructing campaigns against infant mortality and tuberculosis in the early twentieth century, public health authorities in both British and Swedish cities tended to introduce reforms which were broadly in line with local government traditions and could be welded on to existing health services. Instead of formulating fresh strategies, which could have been appropriate in a new situation, policy-makers and the public often either built on old policies or reacted against them. Similarly, decisions which were made in the early twentieth century inevitably curtailed the number of policy options which future decision-makers were to have. Accordingly, the legacy of early twentieth-century choices remains with us today. The purpose of this chapter is to identify and discuss some fundamental patterns and traditions in British and Swedish public health policies which have had an important bearing on the direction and form of public health campaigns. By exploring important continuities and changes in public health policies, it is possible to shed light on and explain differences between policies pursued by Swedish and British health authorities.

Informing this discussion is the 'institutional-political process approach' advocated by Theda Skocpol and Margaret Weir. They argue that public policies are jointly conditioned by social relations and the pre-existing institutional arrangements of the state. Organizational configurations and policy legacies influence the conceptions that policy-makers and the public develop in relation to what central and local governments could do and should do to alleviate economic and social problems. Attention is usually paid to those aspects of problems which can be dealt with by using the existing, or readily foreseeable, 'policy instruments'. Conversely, those aspects which government capacities are not readily adapted to handle are often ignored.


2 Margaret Weir, Ann Shola Orloff and Theda Skocpol, 'Introduction: understanding American social politics', in Margaret Weir, Ann Shola Orloff and Theda Skocpol (eds), The Politics of Social Policy in the United States (Princeton 1988), 3-27; Theda Skocpol, 'Bringing the state back in: strategies of analysis in current research', in Peter B. Evans, Dietrich Rueschemeyer and Theda Skocpol (eds), Bringing the State Back In (Cambridge 1985), 3-
Skocpol and Weir show that different policy legacies and government structures largely explain, for example, the variation in national responses to the economic crisis of the 1930s. Sweden ended up launching deficit-financed public works, firstly, because economic experts had sustained access to strategic centres of public policy and, secondly, because the Swedish government had administered relief works throughout the 1920s. In Britain, by contrast, government structures did not allow economists to participate in policy-making, and in the 1920s efforts to deal with unemployment had been directed to the development of unemployment insurance, not to the administration of relief works. Consequently, the 'Keynesian' route, which would have required new administrative structures, was rejected in Britain in the 1930s.\(^3\)

The purpose of this chapter is to provide a basis for discussion as to how pre-existing administrative structures and policy legacies influence public health policies. It identifies and discusses briefly four factors which explain some important differences between health campaigns in Birmingham and Gothenburg: the strength of the public sector, the primary object of intervention, the social status of public health officials, and the respective powers and jurisdictions of local authorities and central government. Firstly, in Gothenburg and in Sweden generally, the role of the public sector in health care was staggering in the nineteenth and early twentieth centuries. The vast majority of medical doctors, including influential hospital consultants, worked for the public sector and most hospitals were publicly owned. In Britain, in contrast, public provision for sickness was of secondary importance as the core of the health care system was formed by general practitioners and voluntary hospitals.\(^4\) Secondly, until the early twentieth century the main focus of British public health policy was the physical environment, whereas in Sweden the primary object of policy was the individual. Thirdly, Swedish health officials held a strong position in society and were able to construct policies which also furthered their own professional and organizational interests. British public health officials had less latitude in determining policies and furthering their own interests. Fourthly, Swedish central government regulated local health care provision from the seventeenth century, while in Britain central government control was slow to emerge. However, in the early twentieth century, and in particular in the 1920s and 1930s, the Birmingham health authorities were more dependent on central government grants and guidance than their Gothenburg counterparts.

--- SWEDISH PUBLIC HEALTH STRATEGIES ---

In Sweden, central government regulated both public and private health care provision from an early date. At the instigation of influential Stockholm-based physicians and with the support of the Crown, the first

\(^3\) Margaret Weir and Theda Skocpol, 'State structures and the possibilities for "Keynesian" responses to the Great Depression in Sweden, Britain, and the United States', in Evans, Rueschemeyer and Skocpol (eds), *Bringing the State Back In*, 107-63; Heclo, *Modern Social Politics*.

\(^4\) See also Chapter 1, 9-14.
POLICY LEGACIES

regulatory body, the Collegium medicum, was established as early as 1663. The initial purpose of this organization was to restore order in Stockholm's medical market where physicians had to fight competition from other healers, but within a few decades the Collegium medicum developed into a governmental body that supervised health care provision in the entire country. In the eighteenth century, the organization recognized and regulated not only physicians but also barber-surgeons, midwives and pharmacists, distinguishing them from quack healers.

Furthermore, provincial doctors and town physicians, numbering altogether forty or fifty doctors, worked directly under the control of the Collegium medicum. They attended patients but also supervised local health facilities such as hospitals and orphanages and reported regularly on conditions in their respective districts to central government.

Mercantilist thinking was the main motivating force for continuing and increasing government involvement in the medical market in eighteenth-century Sweden. Convinced that a numerous and healthy population was a cornerstone of the nation's power, the Swedish government founded the Statistical Bureau (Tabelverket) in 1749 to ascertain the number of inhabitants in the country and to compile vital statistics which would help authorities devise strategies to increase the population. The report based on the first national registration of the population was not gratifying to the authorities. The population of Sweden (including Finland) was only 2 million, a figure so embarrassingly low that it was immediately declared as top secret. One solution which decision-makers proposed was to improve the health care system and, above all, to combat epidemics. This line of thinking was further reinforced by anxiety over the large number of deaths, both civilian and military, during the Swedish-Russian war in the early nineteenth century.

The new central government department, the Sundhetskollegium, which replaced the Collegium medicum in 1813, controlled all health care services with the exception of hospital administration. The following


6 From 1688 all provinces had an obligation to appoint a provincial doctor. Central government paid the salaries of provincial doctors from 1773, whereas a town physician's salary was paid out of local tax revenue. Hilding Bergstrand, 'Läkarekåren och provinsiallikäresväsendet', in Kock (ed.), Medicinalväsendet i Sverige, 120-31; Gerard Kearns, W. Robert Lee and John Rogers, 'The interaction of political and economic factors in the management of urban public health', and John Rogers and Marie Clark Nelson, 'Controlling infectious diseases in ports: the importance of the military in central-local relations', in Marie C. Nelson and John Rogers (eds), Urbanisation and the Epidemiologic Transition (Uppsala 1989), 33 and 88.


8 Nelson and Rogers, 'Cleaning up the cities', 20; Kearns, Lee and Rogers, 'The interaction of political and economic factors', 32; Rogers and Nelson, 'Controlling infectious diseases', 86.

9 The supervision of general hospitals (lasarett) and hospitals for venereal diseases (kurhus) were entrusted to Sundhetskollegium in 1859. Wolfram Kock, 'Lasarett och den slutna kroppsjukvården', in Kock (ed.), Medicinal-
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decades saw a steady increase in the number of ordinances regulating health care provision in general and the containment of epidemics in particular. From 1813, local parish ministers were obliged to report on the outbreaks of diseases in their parishes to provincial doctors. If the reported disease proved contagious and serious, free medicine was made available and a temporary hospital was set up in order to isolate patients. In 1816, almost four decades earlier than in Britain, smallpox vaccination was made compulsory. In virtually all parts of the country, with the exception of the northernmost provinces and the capital city, the control system functioned efficiently throughout the nineteenth century and the overwhelming majority of the population was vaccinated.10

During the cholera epidemic in 1834, a temporary sanitary committee was established in many Swedish towns to supervise special measures which were taken to attend the victims and to stop the disease spreading. Despite these efforts, the epidemic killed eight per cent of the population in Gothenburg (1,700 people) and five per cent in Stockholm, levels significantly above those in, for example, Liverpool.11 The Epidemic Diseases Act of 1857 (epidemistadga) was concerned specifically with cholera and other contagious diseases. It obliged urban authorities to set up a permanent sanitary committee (sundhetsnämnden) the main task of which was to ensure that necessary precautionary measures were taken against epidemics and that people who became infected were isolated and treated.12 Strategies which focused on the individual - vaccination, isolation hospitals and quarantine, and medical treatment - were clearly given priority in the Swedish public health policy in the mid-nineteenth century.

This emphasis on the individual manifested itself not only in the campaigns against epidemics but also in measures which were taken to contain venereal diseases (VD). Throughout the nineteenth century, Swedish health authorities devoted a considerable proportion of their resources to hospital treatment for VD and, in particular, for syphilis. In 1820, not less than 60 per cent of all hospital beds in Sweden were allotted to patients with VD, in 1881 it was still 17 per cent.13 Furthermore, during the second half of the nineteenth

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Policy legacies

The second half of the nineteenth century saw the proliferation of health care services in Swedish towns. The rapid growth of services was possible, firstly, because local authorities assumed wide responsibilities regarding personal health care and, secondly, because they did not develop health care within the confines of the poor law system. Owing to the active government involvement, health-care provision in Sweden was soon comparable to services available in more affluent societies such as Britain and Germany. Swedish hospital provision in particular stood comparison with the British one, a considerable achievement given the wide discrepancy in levels of wealth. In late nineteenth-century Gothenburg, municipal authorities ran a workhouse infirmary but also general hospitals and a number of special hospitals. While the infirmary provided hospital treatment for the destitute, the general hospitals catered mainly for working-class and lower-middle-class people who were deemed able to contribute something towards their treatment and upkeep. A small number of private rooms were set aside for well-to-do middle-class patients. The municipal maternity hospital was opened in 1875 and by 1900 the number of maternity beds rose from 24 to 63. Furthermore, the first permanent epidemic hospital was established in 1886 and a new hospital for patients with VD was opened in 1894.


15 *Göteborgs hälsovårdsnämnds årsberättelse* (hereafter *Årsberättelse*) for 1914, 20-1.


In the first half of the nineteenth century, Swedish health authorities had committed themselves to strategies which focused on the individual, paying very little attention to environmental questions. In the 1850s and 1860s accounts of urban health problems became more eclectic, in Stockholm and Gothenburg at least. Awareness of environmental problems increased and new opportunities to widen the sphere of municipal action developed. Firstly, the 1857 Epidemic Diseases Act required, though in rather vague terms, local sanitary committees to examine the sanitary condition of their towns and, if necessary, to take measures and to give advice to townspeople as to how to deal with sanitary problems. Secondly, the local government reform in 1862-63 paved the way for more ambitious public intervention. Former governing bodies dominated by the traditional middling class, shopkeepers and artisans, were replaced by a town council representative of all ratepayers. The multi-vote system favoured those with large incomes and in consequence leading businessmen and manufacturers were, to a large extent, able to determine the direction of municipal policy. Many of them were convinced that liberal public spending had its virtues. Furthermore, resources yielded by local taxes were no longer earmarked for particular purposes which meant that local policy-makers had a greater amount of latitude in how they spent the money than their predecessors had had. These changes created an atmosphere which was relatively favourable to sanitary reforms and to the development of urban infrastructure.

However, policy-makers were slow to seize these new opportunities. Several towns constructed water pipes in the 1860s in the central districts where middle-class families lived, but did not provide other residential areas with the same facilities. Furthermore, only Gothenburg and Stockholm established a waste-water disposal system in the 1860s, while Malmö, the third-largest town, postponed the construction of sewerage until 1890 and Lund until 1900. Attempts to mitigate the problem of insanitary housing were even less enthusiastic, although local building ordinances gave authorities some means of dealing with this question. Many medical doctors and social reformers were in favour of stricter regulation, but parliament was reluctant

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19 See, for example, HansNilsson, 'Halsa och stadsrenhållning under 1800-talet', Nordisk Arkitekturforskning 8 (1995), 24. In the late nineteenth century, businessmen and industrialists played an important role in determining municipal policies in many Swedish towns. For the economic and political élites in Gothenburg, Uppsala, Jönköping and Enköping, see Martin Åberg, En fråga om klass? Borgarklass och industriellt företagande i Göteborg, 1850-1914 (Göteborg 1991); Britt Marie Olsson, 'Stadens styrelse - ett upplyst fävärde', in Lili Kaelas and Kristina Söderpalm (eds), För hundra år sedan - skildringar från Göteborgs 1880-tal (Göteborg 1984), 227-40; Nelson and Rogers, 'Cleaning up the cities', 28-38; Bengt Berglund, Jan Christensen and Robert Thavenius, Liberalernas Jönköping: Stad i omvandling 1825-1875 (Jönköping 1990); Bertil Johansson, Social differentiering och kommunalpolitik: Enköping 1863-1919 (Uppsala 1974).

20 Elias Heyman, Studier i allmän hälsovård grundade på Göteborgs mortalitetsförhållanden (Göteborg 1877), 25; Carl Lindman, Dödligheten i första lefnadsåret i Sveriges två större städer 1876-95 (Stockholm 1898), 126-7; Reinhold Castensson, Marianne Löwgren and Jan Sundin, 'Urban water supply and improvement of health conditions', in Bärdström and Tedebrand (eds), Society, Health and Population, 273-98; Wetterberg and Axelsson, Smutsgruld och dödligt hot, 97-120; Nilsson, 'Halsa och stadsrenhållning', 19-26; idem, Mot bättre halsa, 66-7; Kearns, Lee and Rogers, 'The interaction of political and economic factors', 72, table 46.
to circumscribe the rights of property owners. In Gothenburg, Dr. Elias Heyman, a member of the sanitary committee, studied local health and housing conditions and demanded more wide-ranging sanitary measures. His demands fuelled a dispute over sanitary policy which culminated in Heyman leaving Gothenburg for Stockholm in the early 1870s.

The first comprehensive public health act, which was influenced by both British and German public health legislation, was introduced in 1874. This act required municipalities to set up a public health committee consisting of the city physician, the police chief, a representative of the magistrate, and four other members which were to be appointed by the town council. The responsibilities of this committee included the management of sewers, drains and water supply, the control of the sanitary condition of rented houses and flats, and the regulation of the sale of foodstuffs. Moreover, the Public Health Act broadened the responsibilities of medical doctors. They had to notify the public health authorities of all cases of cholera, smallpox, typhus, typhoid fever, scarlet fever, diphtheria and dysentery. In Britain, the equivalent act was introduced somewhat later, in 1889. This new legislation provided fresh impetus for local authorities who had already taken measures to control the urban environment and it stirred into action authorities who so far had not launched any programmes for sanitary reform. Despite these important reforms, Sweden clearly lagged behind Britain in sanitary engineering in the late nineteenth century. The acute-care model which concentrated on the individual and gave priority to medical care was the tradition that early twentieth-century health authorities in Gothenburg and other Swedish cities inherited from their predecessors.

As the public provision for sickness was not subordinate to poor law in Sweden, the 'respectable' working class and lower middle class did not view this provision with the same profound distrust as these social groups did in Britain. However, Swedish authorities pursued individualistic health strategies such as vaccination at an early stage and with a great degree of compulsion, and in some cases they obviously failed to convince the public that these measures were an appropriate and safe way to deal with problems. Predictably, most vehement objections were raised to reforms which gave compulsory powers to health authorities and, therefore, clearly impinged on the individual's right to make their own decisions in matters concerning their health. Opposition to these measures did not draw solely on one single scientific paradigm or moral conviction but was motivated by different sets of values and views, as the vaccination debate indicated. Some people condemned vaccination as an interference in God's plan, whereas others called into question the effectiveness and safety of this measure. Furthermore, a number of opponents directed their
main criticism at the coercive nature of the vaccination legislation. They saw compulsory vaccination as a measure whereby an overprotective, paternalistic state and a power-seeking medical profession eroded individual liberty in a matter which primarily concerned the individuals themselves. Protests against the vaccination legislation were, however, staged rather sporadically and they did not develop into an organised anti-vaccination movement in Sweden. The campaign against the compulsory screening and treatment of prostitutes suffering from venereal diseases did not come any closer to success, although it was more organized than the anti-vaccination activity.24

--- BRITISH PUBLIC HEALTH STRATEGIES ---

Before the nineteenth century, the British government showed little interest in guiding local communities in questions concerning health care and environmental cleanliness. Central control, as Christopher Hamlin has pointed out, was almost non-existent: "to a large degree counties, boroughs, and parishes were responsible for their own affairs, each conducting these with its own traditions, institutions, and ineptitude."25 Hence Britain had virtually no national public health legislation when cholera appeared in the country in 1831. Political pressures to guide local policy-making and to enforce some degree of uniformity had been increasing over the preceding decades but it needed a serious crisis such as cholera to actually put public health issues on the national agenda. A temporary central government body, The Board of Health, was established specifically to deal with the cholera epidemic, and another response to the pressures to create centralized bureaucracies was the Poor Law Amendment Act of 1834. The Poor Law Commission, the new central authority, and local poor law unions provided the first administrative network with national coverage of both urban and rural areas. This network was used, for example, to provide a vaccination service for the entire population.26

While British authorities expressly asserted the non-pauperising nature of the vaccination service, all other poor law medical services were tainted by the stigma of pauperism. The subordination of public provision for sickness to the poor law administration caused some obvious problems. Firstly, a system which actively

24 For the anti-vaccination movement in Sweden, see Nelson and Rogers, 'The right to die?'; Bergman, 'De epidemiiska sjukdomarna', 348-51; Charles Dickson, 'Om dödligheten hos spåda barn'. Götheborgs Kongl. Vetenskaps och Vitterhets Samhälles Handlingar. Ny tidsföljd. 6 Häftet (1859). Compared with the British (see below in the text) and in particular with the French anti-vaccination movement, Swedish activity was small in scale. On the French anti-vaccination movement, see Pierre Darmon, La longue trague de la variole: Les pionniers de la médecine préventive (Paris 1986). For protests against the regulation of prostitution, Lundquist, Den disciplinerade dubbelmoralen, 408-21; Karlsson, 'Anpassning eller protest?'; Hjördis Levin, Kvinnorna på barrikaden: Sexualpolitik och sociala frågor 1923-36 (Stockholm 1997).


discouraged people from applying for medical relief even when they urgently needed it could not be effective in alleviating health problems. Secondly, the development of poor law medical care was seriously hampered by the principle that all health services which provided for the destitute ought to be inferior to the medical treatment which "independent labourers" obtained through sick clubs, friendly societies and voluntary hospitals. In the late nineteenth century, after a number of well-publicized scandals had drawn the public's attention to the state of the sick poor, efforts were made to remove some of the ambivalence which pervaded the service. Poor law infirmaries eased the requirement of destitution, admitting also non-pauper patients, and the standard of care and the level of amenities were gradually being raised. Infirmaries were separated from workhouses, consultants and resident medical officers were appointed and pauper 'nurses' were replaced by trained nurses. Despite these changes, poor law infirmaries did not compete on equal terms with voluntary hospitals. In many cities poor law infirmaries provided more than half of all hospital beds at the turn of the century, but they were mainly catering for chronic and long-term patients who were excluded from voluntary hospitals.

Public health authorities, on their part, were reluctant to take on any responsibilities regarding personal health care. The last decades of the nineteenth century saw a piecemeal extension of the number of municipal hospitals, but these institutions were almost exclusively designed to isolate and treat patients who were suffering from infectious diseases. Furthermore, in many cases, hospital reform only came about through central government bringing pressure to bear on local authorities. Any wider vision of municipal commitments was repudiated by most decision-makers, who regarded personal health care services either as private and voluntary ventures or, in the case of indigent patients, as the responsibility of poor law authorities. For example, although local authorities were empowered to establish general hospitals as early as 1875, by 1906 only two authorities had made use of these statutory provisions. Most local authorities, the Birmingham authorities included, did not start to run general hospitals until the poor law infirmaries were transferred to them in 1929.


28 Kearns, Lee, Rogers, 'The interaction of political and economic factors', 18, 56. See also, Pinker, English Hospital Statistics, 60-8.


The focus of British public health policy was pre-eminently environmental throughout the nineteenth century. In the first half of the century, initiative lay entirely with local authorities and the pace of reform varied enormously from place to place. Large and wealthy towns, with a few notable exceptions, were the moving force behind attempts to tackle urban environmental problems. In drafting local improvement acts which would empower them to control the rapidly changing urban environment, they played a dominant role in identifying and defining new statutory needs. Other towns followed in their wake, preparing more limited acts or taking over clauses from the local acts of these pioneering towns. In the mid-nineteenth century, the central government finally assumed a more active role in the field of public health. One of the first general acts was the Public Health Act of 1848 which empowered local authorities to establish a local Board of Health and to appoint a Medical Officer of Health (MOH), to control houses unfit for human habitation, to manage sewers, drains, wells and water supplies, to remove nuisances and to regulate offensive trades. Local authorities were also given the right to levy local rates and purchase land which were essential prerequisites of effective implementation of the new legislation.31 Furthermore, the 1848 Act established a new central government department, the General Board of Health, to deal with public health problems and to supervise local authorities in sanitary questions. Its responsibilities were transferred to the Privy Council in 1854 and again to the Local Government Board in 1871.32

In the 1850s and 1860s local authorities could either adopt powers conferred by general acts or continue to draft local acts. The Birmingham authorities, suspicious of any interference from central government, refused to adopt, for example, the 1848 Public Health Act and drafted a local improvement act instead.33 Despite the fact that most of the public health legislation was optional until the late nineteenth century, central government had a considerable influence on public health strategies pursued in English cities. Central government was, to an extent, able to define urban health problems by directing local authorities' attention to some questions and by allowing them to ignore others. Furthermore, they recommended some responses to health problems and remained silent on alternative solutions. For example, Edwin Chadwick and other 'ultra-sanitarians' in central government mounted a sustained and successful campaign to convince local policy-makers that epidemic diseases were a product of dirt and decomposing matter and that environmental measures were the answer to these problems. However, not everyone was entirely happy with this narrowly focused


33 Hennock, *Fit and Proper Persons*, 4-6.
POLICY LEGACIES

definition. Many doctors and reformers, as John V. Pickstone has pointed out, recognized and emphasized also the connection between deprivation and diseases.34

By categorising towns and districts as healthy or unhealthy on the basis of mortality league tables, central government managed to shame some towns with high death rates into activity. At the same time, comparative tables provided towns with low overall death rates, like Birmingham, with an excuse for not taking decisive action to alleviate environmental problems in their slum areas.35 Birmingham was a relatively healthy industrial town in the mid-nineteenth century. It was spared the worst ravages of cholera in both 1832 (21 deaths in Birmingham, 1,523 in Liverpool) and 1849 (29 deaths in Birmingham, 5,308 in Liverpool) and it stood favourably in the league tables. Yet the death rates for the central wards of the city were high and in 1849 the Inspector of the General Board of Health, Robert Rawlinson, reported many serious environmental problems in the city such as "indescribable filthiness" of streets, canals and rivers. Central government's one-sided attention to overall death rates and local decision-makers' determination to keep rates low made Birmingham one of the most backward boroughs in the country in the 1850s and 1860s.36 Health and sanitary problems received systematic attention only after the appointment of the first MOH in 1873. Birmingham made this move a quarter of a century later than the pioneers, Liverpool, Leicester and London, and even in the early 1870s a large number of Birmingham policy-makers were of opinion that a Medical Officer was a luxury which they neither needed nor could afford.37

The public health legislation of the 1870s contained a significant number of compulsory clauses, leaving local authorities less room for manoeuvre. However, this was not the only reason why attitudes to public health questions were changing in Birmingham. The economic elite of the city, leading businessmen and manufacturers, who had eschewed factional local politics in the 1850s and 1860s, gained control over local decision-making by the early 1870s. They were fully aware of the significant benefits which more liberal public spending would bring to them personally and to the town in general and in consequence they started to


37 Wohl, Endangered Lives, 179-82; Hennoch, Fit and Proper Persons, 111-6. The Local Government Board (LGB) offered to pay half of the Medical Officer's salary on condition that it approved the appointment. The Birmingham City Council declined the offer in order to ensure that central government interfered in local politics as little as possible. In 1875, the Council reconsidered its stance and accepted LGB's contribution.
policey legacies

steer municipal politics to a new direction. The MOH for Birmingham, Dr. Alfred Hill, devoted the first ten years of his tenure to bringing the local public health administration and sanitary policy into line with other large British cities and to tackling problems which had been neglected for years. Birmingham clearly had some catching up to do.

When municipal intervention in the management of private property grew more ambitious, small property owners voiced their strong concern that, while they were made to pay for environmental and sanitary reforms, other groups reaped the benefits. Their concern was not entirely groundless. New environmental regulations left some marginal landlords and workshop owners in desperate financial straits. However, environmental regulations did not seriously erode property rights, and this was the message which Chadwick and other leading sanitary reformers sought to get across. They sold national and local policy-makers on the notion that public health reform was a means of ensuring that capitalist market relationships operated effectively and that imperfect competition and other abuses were minimized. The redefining of property rights was, as Gerry Kearns have noted, "presented as an abstract defence of the virtues of free markets and the dangers of imperfect ones."

Although British authorities pinned their hopes on sanitary engineering, they adopted some individualistic public health strategies in order to prevent and contain epidemics. The launching of these strategies often met with angry protests. For example, during the cholera epidemic in 1831-32 some working-class people perceived emergency measures as an unnecessary disruption to their every-day life and as a threat to their established rights, and in consequence they responded to these measures either with passive disobedience or with violent resistance. Similarly, protests against compulsory vaccination and against the regulation of prostitution attracted support. Both these protest movements, which educated public opinion in non-metropolitan areas and influential political circles in London, were eventually able to claim success. The campaign against the regulation of prostitution achieved its aim in 1886, when the Contagious Diseases Acts were repealed. The movement protesting against the compulsory vaccination won a compromise. The

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38 BPRO, Birmingham Health Committee (HC), minutes 23. 7. 1901 item 6933; 10. 6. 1902 item 7478; 9. 12. 1902 item 7774; Annual Reports of the Medical Officer of Health for Birmingham (hereafter Annual Report) for 1872-1900 and in particular for 1874, 15-7; for 1882, 3-4; for 1885, 57-67; for 1888, 46-53; for 1897, 6-10, 20-33; for 1898, 8-15, 34-40. See also, A. Mayne, The Imagined Slum: Newspaper Representation in Three Cities, 1870-1914 (Leicester 1993), 57-97.

39 Alfred Hill was influential also at the national level. He was, for example, the first president of the Society of Medical Officers of Health which came to being in 1889 as a result of the amalgamation of the Metropolitan association and various regional associations. Dorothy Porter, 'Stratification and its discontents: professionalization and conflict in the British public health service, 1848-1914', in Elizabeth Fee and Roy M. Acheson (eds), A History of Education in Public Health: Health that Mocks the Doctors' Rules (Oxford 1991), 105-12.

conscience clause which enabled parents to refuse permission for health authorities to vaccinate their children was introduced by the Vaccination Act of 1898.41

--- PUBLIC HEALTH EXPERTS AND THE NEW HYGIENE ---

In the late nineteenth century, British and Swedish public health policies were converging. The British health policy shifted decisively away from environmental concerns to a more individualistic focus. However, the new individualistic strategies which the British public health authorities devised at the turn of the century were not similar to traditional Swedish strategies. The new techniques of analysis were not primarily fixed to identify disease in individual bodies but, as David Armstrong has pointed out, "in the spaces between people, in the interstices of relationships, in the social body itself."42 Swedish health policy was gradually steered in the same direction. Disease became increasingly constituted in the social body rather than the individual body, and it was monitored by various agents in the community.43 In both Birmingham and Gothenburg, the crude death rate declined throughout the period reviewed here, giving the health authorities an opportunity to praise their new approach for good results (See Figure 3.1).

The appointment of Dr. Karl Gezelius as the First City Physician for Gothenburg in 1901 clearly illustrates the new attitude. According to regulations governing the appointment, the minimum qualification for the post was three years experience as a provincial doctor or a town physician. In 1900, the Health Committee expressed its concern that the City Council, which had to obey these regulations, would give the job to a senior health official as a reward for his loyal service to local authorities or to the Crown. The Health Committee managed to convince the City Council that it was a matter of utmost importance and urgency to appeal to central government to change the regulations. Whether this action was primarily prompted by a resolve to appoint Karl Gezelius, who was not qualified under existing regulations, or a desire to keep up

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with the time is not explained in official documents. What is interesting, however, is the way in which the Health Committee justified their appeal to central government.

**Figure 3.1. Crude death rate per 1,000 inhabitants in Birmingham and Gothenburg, 1890-1938**


The Health Committee claimed that much of the great sacrifices the city had made to improve the health of its population would be wasted, if the health policy was directed by a medical doctor whose main qualification was a long career in the public service. Practical knowledge of administrative systems and procedures was, they said, an overrated merit, which alone did not render a medical doctor equal to the demands of this important post. Ratepayers would get value for their money only if the Public Health Department was led by an official who was able to grasp the underlying principles of health issues and capable of finding scientific solutions to pressing medical and social problems. In other words, instead of a bureaucrat the Health Committee was looking for a young aspiring scientist who had a first-rate medical education, was interested in research, and was familiar with the new 'hygiene movement'. Although the National Board of Health (*Medicinalstyrelsen*) disagreed with the Gothenburg Health Committee, stressing the importance of administrative experience, the regulations were eventually amended.44 Karl Gezelius, who had worked in a pathological institute and in general hospitals and had taken several study trips both to

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44 *Göteborgs Stadsfullmäktiges Handlingar (GSH)* 1900:13, 1900:78 and 1900:156, and minutes 1. 3. 1900 item 2; 31. 5. 1900 item 11.
Central Europe and to Britain, was appointed as the First City Physician for Gothenburg. The public health department was under his leadership until 1931.45

Karl Gezelius, like many other health officials in Swedish towns, participated in the development of municipal health and welfare policies in various roles. He was a member of the City Council from 1903 to 1910, a member of the Public Health Committee from 1900 to 1932 and the chairman of the Public Health Committee's second division from 1920 to 1929. The second division was responsible for running municipal hospitals. Hence he had a key determining role in planning health policies, but he also participated in the actual decision-making in the Health Committee and City Council. Furthermore, he was active in voluntary and professional associations. For example, from 1903 to 1908 he was the chairman of the voluntary association which operated milk depots in Gothenburg and in 1920 he was the chairman of the local Medical Association (Goteborgs läkaresällskap).46

Although Swedish government had been active in controlling health care provision from an early date, in the early twentieth century and in particular 1920s and 1930s, the Gothenburg Health Committee and the First City Physician were probably more influential in shaping local health policies than their counterparts in Birmingham. In Sweden, where the state was heavily involved in providing and funding health care services in the sparsely populated countryside, large towns were left pretty much to themselves. Public health care services in towns were, to a very large extent, financed locally and in consequence local policy-makers had considerable latitude in how to develop municipal health services. The anti-tuberculosis scheme was an exception. From 1909-10 onwards, local authorities were eligible for central government grants to establish and maintain tuberculosis sanatoria and hospitals. This meant that local authorities had to bring their anti-tuberculosis schemes broadly into line with government recommendations.47

In the early years of the twentieth century, Birmingham was also looking for an innovative Medical Officer. At that time the city's progressive tag was largely a rhetoric masking the inefficiency of the local administration and the dissension among policy-makers. The Health Committee, which came in for a great deal of criticism, was acutely aware that it was of the utmost importance to appoint a MOH who could steer a new course in public health and give credibility to the health policy. Dr John Robertson, who was appointed, had previously held the post of MOH for St. Helens and for Sheffield.48 His obituaries in 1936

45 Karl-Johan Gezelius (1866-1947) was the acting First City Physician for Gothenburg from 1900 to 1901 and the First City Physician from 1901 to 1931. For biographical details see, N. J. Wellinder, Biografisk matrisel over svenska läkarkåren 1924 (Stockholm 1924); Magnus Fahl, Goteborgs Stadsfullmäktige 1863-1962. I: Biografisk matrisel (Göteborg 1963).

46 See Årsberättelser för 1900-1931; Fahl, Goteborgs Stadsfullmäktige 1863-1962.


48 For the appointment of the MOH, see HC, minutes 6. 4. 1903 item 8009; 13. 5. 1903 item 8058; 24. 6. 1903 items 8111-2; 14. 7. 1903 item 8146.
praised him for introducing bacteriological research into the field of municipal health care while he was working in St. Helens and Sheffield.

In 1891, out of nearly sixty applicants, he was chosen for the appointment of medical officer of the county borough of St. Helens, where he also served as municipal superintendent of the fever hospital and as public analyst. Here he undertook extensive investigations into the combating diphtheria, and was responsible for probably the first bacteriological work done under municipal auspices in this country. Bacteriology was always one of his preoccupations. From diphtheria he turned his attention to a systematic inquiry into the causes of endemic typhoid fever, with valuable results which have been recognized at home and abroad. Six years were spent at St. Helens, and then he removed to Sheffield, where he was medical officer of health and professor of public health and lecturer in bacteriology in the then newly established university. At Sheffield he again showed his initiative in the promotion of the first local Act of Parliament for making the notification of tuberculosis compulsory and in the measures he set on foot for the reduction of infant mortality.49

To enable Robertson to co-ordinate public health work efficiently, the Birmingham Health Committee reorganized and centralized the Public Health Department immediately after his appointment. More power was concentrated in the hands of the MOH who was to supervise, directly or indirectly, all public health officials in Birmingham.50 Robertson was also active in various voluntary societies and professional associations and published two books on housing and health.51 Yet he was less influential in shaping the municipal health policy than his counterpart in Gothenburg. Unlike Karl Gezelius, Robertson was not a member of the City Council or the Health Committee, and in the 1920s he was no longer allowed even to attend the meetings of the Committee.

In Britain, central government became more involved in the infant welfare and anti-tuberculosis campaigns from the second decade of the twentieth century. The 1911 National Insurance Act, the introduction of compulsory notification of tuberculosis in 1913, and the 1921 Public Health (Tuberculosis) Act gave municipal authorities wide responsibilities for the prevention and treatment of tuberculosis. Government grants were available on the condition that the sanatoria and hospitals which local authorities built met the standards required by central government and that medical doctors and nurses whom local authorities appointed had the necessary qualifications. This was also the case with the infant welfare work after the Maternal and


50 HC, minutes 12. 1. 1904 item 8402; CC, minutes 1. 3. 1904 items 19 304, 19 305 and 19 307.

Child Welfare Act was passed in 1918. In the 1920s, central government grants covered up to 50 per cent of the approved expenditure on both tuberculosis and child welfare services. However, although the role of central government became more important during the interwar years, it seems that local authorities were still "the major source of initiative and of increased expenditure." Local policy-makers had a say in how much was spent on health care services and consequently there were considerable geographical variations in municipal health care provision in the interwar years. As Hilary Marland has argued, and as the following chapter shows, "(e)ven after the passing of the Maternity and Child Welfare Act in 1918, its implementation remained largely a question of local interpretation and policy-making.

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55 Marland, 'A pioneer in infant welfare.'
REGULATING FAMILY LIFE: CAMPAIGNS AGAINST INFANT MORTALITY 1900-40

"It has become fashionable and somewhat convenient to place the blame for (social) problems on the family, thereby highlighting the dangers associated with its apparent demise as the cornerstone of a stable society, and justifying the need to find ways of preventing further deterioration."

Janet Walker, 'Interventions in families' (1991)¹

In launching their campaigns against infant mortality in the early years of the twentieth century, British and Swedish public health authorities were acutely aware that they were building on the shifting sands of opinion. Having identified the diseases which made the most significant contribution to the high rates of infant mortality, they had to acknowledge that science provided few immediate answers as to how to fight these major killers. Firstly, in both Britain and Sweden, the most common causes of deaths occurring within the first month of life (neonatal mortality) were prematurity, congenital defects and birth injuries. These causes of death had inspired some research which linked neonatal mortality to the quality of maternity care, hereditary characteristics of the parents, general health of the mother and her economic and social circumstances. However, experts were incapable of explaining exactly how these different factors operated and rather helpless to prevent the death once the child was born.²

Secondly, most deaths within months two to twelve (post-neonatal mortality) were attributable to infantile diarrhoea and respiratory diseases. Despite the intense scrutiny to which the problem of infantile diarrhoea had been subjected, the transmission and behaviour of this disease remained a source of confusion and argument in the early twentieth century. Most public health officials, general practitioners, epidemiologists

¹ Janet Walker, 'Interventions in families', in David Clark (ed.), Marriage, Domestic Life and Social Change (London 1991), 188.

and bacteriologists agreed that bottle-feeding was a major risk factor especially in poor working-class homes, but the question of what other factors contributed to the prevalence of diarrhoea and what measures would be the most appropriate encouraged no such consensus. As regards respiratory diseases such as bronchitis and pneumonia, much of their aetiology was unclear, and public health experts usually confined themselves to stating that exposure to cold and damp made infants susceptible to these diseases.

For a while health authorities were clearly uncertain about what was to be done, when and where, and for whom, even though they did not start their campaigns from scratch. Public concern over the high rates of infant mortality had surfaced several times in the course of the nineteenth century, and some measures had already been taken in both Britain and Sweden to reduce mortality. How effective these measures were in saving infant lives is open to debate, but they certainly served to accustom the public to state interference in family relations and to the growing authority of the medical profession.

**Policy legacies**

In Britain, infant mortality and infanticide emerged as acute public problems in the 1860s. Medical doctors, the police and the press, who all stood to gain something out of the crisis, defined the problem, focusing their attention on 'baby-farmers'. This term was used to describe working-class women who offered to take care of babies for a small weekly payment or a larger lump sum. Parents who placed their children in the care of baby-farmers were usually unmarried mothers, widows or widowers who worked for living and thus were unable to look after their children. A large proportion of the children died or, as critics argued, were murdered by the baby-farmers, the wicked 'anti-mothers'. Around 1870 the debate about baby-farming widened to moral panic, culminating in the trial and execution of "a notorious baby-farmer" Margaret Waters. Two years later, in 1872, troubled public conscience moved Parliament to pass the Infant Life Protection Act that required 'professional' child-carers to register with the local authorities. The Act, which attacked only the worst cases of baby-farming, was to have little effect on infant mortality, but it was an important change

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in gender politics, a step towards the 'biologicalization of motherhood'. A similar change was on its way in many other countries, as Danish historian Anne Løkke has pointed out: "whereas wet nurses, nannies, grandmothers, fostermothers, older sisters, and the like had previously been accepted as substitute mothers, it gradually became the right and duty of the mother herself to look after her young children."\(^5\)

Not everyone agreed that the execution of Margaret Waters and the passage of the Infant Life Protection Act were appropriate measures to deal with the problem. Some feminists who opposed state interference in the most important area of female responsibility, the care of children, reacted strongly against the measures. They argued that medical men, the police and the press had just gone in search of a scapegoat and found an easy target in poor women. By blaming working-class women, the opinion-forming groups had side-stepped many important causes of infant death and exonerated men, and especially the fathers of illegitimate children, from responsibility.\(^6\) Feminists were by no means alone in arguing that the question should be placed in a wider context. The Medical Officer of Health (MOH) for Birmingham, Dr. Alfred Hill, who examined the issue in the 1870s and 1880s, was convinced that "improper feeding and careless nursing" were the principal causes of infant death, but at the same time he stressed that the problem also had "a sanitary side." He wished that "philanthropic ladies" would establish day nurseries and instruct poorer classes "in the simple canons of Infant Management," and he urged the Birmingham Health Committee to intensify its efforts to deal with overcrowding, contaminated water and defective drainage.\(^7\)

Swedish authorities were deeply concerned about the high rates of infant mortality as early as 1760s and 1770s. The Swedish government, strongly influenced by mercantilist thinking, had founded the Statistical Bureau in 1749 to provide data which would permit an analysis of population trends. In the 1760s statistician Per Wargentin used this material to calculate mortality according to age and thus he also produced a figure which is now called infant mortality. These calculations revealed, or rather confirmed the fears, that one-fifth of infants died during the first year of their life and that in many northern parishes infant mortality was between 400 and 500 - meaning that out of every 1,000 children born, 400-500 died before reaching their first birthday. These figures made depressing reading for the government which was convinced that "(i)n the multitude of people is the King's honour: but in the want of people is the destruction of the prince."\(^8\)


\(^7\) Alfred Hill, Report to the Health Committee on Infantile Mortality in the Borough of Birmingham (Health Department, Birmingham 1877); idem, 'The president's address', *Public Health* 1 (1988), 3-5; *The Annual Report of the Medical Officer of Health for Birmingham* (hereafter *Annual Report*) for 1877, 6-10, for 1880, 22-3.

The concern over the high infant mortality in the late eighteenth and early nineteenth centuries prompted Swedish authorities to carry through some reforms, the most important of which was the campaign to train and regulate midwives. The basic principles of this reform were formulated by medical doctors and thus it served their professional interests. Unlike British doctors, Swedish doctors were all in favour of the training of midwives as long as they themselves had power to define the content of the training programme and to regulate the practice. In sparsely populated Sweden, where most medical men preferred to practise in towns, trained midwives played a major role in the campaign against folk healers and the traditional forms of treatment upon which the rural population still largely relied. Midwives were well suited to bridge the distance between medical science and popular culture both in the countryside and among the urban working class, since the majority of them came from a social milieu similar to that of their clients.

Trained midwives dealt with 'normal' deliveries but they were also allowed to perform obstetric operations and were expected to instruct mothers in infant care. Historians who have examined the reform have found some evidence that trained midwives lowered maternal mortality and strong evidence that they reduced infant mortality. In particular, the campaign to persuade mothers to breast-feed appears to have reduced the number of deaths from infantile diarrhoea. In Sweden, infant mortality fell steadily throughout the nineteenth century, from 204 per thousand live births in 1801 to 103 in 1901, whereas in Britain, Germany and France mortality did not begin its secular decline until the late nineteenth century. However, in the opinion of Swedish doctors, the decline could have been more dramatic if only people had taken full advantage of the


help that medicine offered. A pre-eminent physician who practised in Gothenburg in the mid-nineteenth century, Dr. Charles Dickson, argued that infant mortality remained high partly because parents were ignorant of how to care for infants and how to nurse childhood infections, and partly because they turned to their relatives and neighbours for assistance in questions of life and death instead of seeking medical advice.12

Explicit and implicit motives

At the turn of the twentieth century, campaigns against infant mortality took on new colour and urgency in Britain and Sweden. Public health authorities, who were under considerable pressure to find fresh approaches to the problem, looked first to other countries for new ideas. In 1902, British legislators followed the example set by Sweden and the Netherlands by taking the first hesitant step to regulate midwives. In the same year, the Swedish Parliament passed a law which placed local authorities under a duty to supervise families who fostered for pay; a reform which was modelled on the British legislation.13 Moreover, both British and Swedish authorities took an active interest in French reforms. Baby welfare clinics established by Pierre Budin, Gaston Variat and Léon Dufour emerged as the most innovative measures against infant mortality in the early twentieth century. These ideas were imported into Britain and Sweden, and the names of Budin, Variat and Dufour figured prominently in the reports of British and Swedish local authorities and voluntary associations.14 The new infant welfare movement was clearly an international venture.

What also distinguished the early twentieth-century campaigns from their forerunners was the role of medical expertise and experts. Doctors had not stood on the sidelines in the nineteenth century, but they had not had monopoly on the questions of infant welfare either. For example, in Britain the police had claimed relevant expertise to deal with infanticide and infant mortality. In the early twentieth century, however, medical doctors clearly developed the strongest claim to authority on this matter.15 Consequently, after a short period of uncertainty and experimentation, medical and scientific knowledge came to play a pivotal role in the legitimation of policy decisions. Despite the fact that contemporary science did not provide unambiguous

12 Charles Dickson, 'Om dödligheten hos spåda barn', Göteborgs Kongl. Vetenskaps och Vitterhets-Samhälles Handlingar (Göteborg 1859), 3-24.

13 Loudon, Death in Childbirth, 402-21; Hagb. Isberg, 'Barnavård', in G. H. von Koch (ed.), Social Handbok (Stockholm 1908), 72-3. For Birmingham, see Annual Report for 1905, 53-6 and for Gothenburg, see Göteborgs hälsovårdsnämnds årsberättelse (hereafter Årsberättelse) for 1902, 3; for 1903, 2.


answers to the problem, policy-makers in both Birmingham and Gothenburg emphasized their faith in the
capacity of science to indicate the 'real' causes of infant death and to specify the measures to be taken. New
policies were justified by showing, or just claiming, that there was enough scientific evidence to support
them, and when policy-makers wanted to reject ideas or postpone decisions, they usually argued that the
issues in question were still subjects of intense scientific controversy.

In particular in Birmingham, where the status of public health officials was not secure and the problem of
infant mortality amounted to unprecedented political proportions, meticulous care was taken to ensure that
the basic tenets of the campaign could be defended as scientific and rational. In defining the problem,
Birmingham authorities and especially the MOH, drew upon a full arsenal of contemporary scientific findings
- statistical information on infant mortality, clinical observations of diseases, surveys of feeding practices,
theories about energy requirements, bacteriological analyses of milk, and poverty surveys conducted by
Rowntree and Booth - to support their analyses. Health authorities were clearly aware that they could do
their work without constant oversight only if they convinced other policy-makers and the public that the
campaign was based on a firm foundation of facts. In Gothenburg, where the status of health officials was
higher and where infant mortality was not an acute political problem, the push for 'scientific rigour' in public
health debate was somewhat weaker. Health officials did not always need to justify their decisions by
scientific evidence but were allowed to use their expert judgement. However, the importance of science as
legitimizing rhetoric increased, when different views about infant welfare emerged by 1910.

No matter how convincing authorities were in their efforts to link the infant welfare campaigns to medical
knowledge, it was obvious that scientific progress and humanitarian concern were not the only moving force
behind the campaigns. This was even admitted by contemporary observers. They suggested three factors to
explain the surge of interest in infant welfare. Firstly, they credited "a few individuals of exceptional public
spirit" with having drawn attention "to the evils that beset child life" and having forged alliances to deal with
the problems. Secondly, the infant welfare movement was associated with social progress. In an advanced
state of civilization people came to realize "that the community as a whole was responsible for the welfare of
its children." Thirdly, contemporaries stressed that the high mortality rate was an issue which deserved "the
most serious consideration by all true patriots", since it posed a threat to national security and prosperity.

The same insistence on the importance of national interests in explaining the proliferation of infant welfare
services can also be found in the works of many present-day scholars. Anxiety about foreign competition
and fear of racial deterioration, it has often been argued, were the most important factors stimulating the
interest in infant welfare. In Britain, politicians and social reformers feared that high infant mortality,

16 Special Report on Infant Mortality. See also, Newman, Infant Mortality; Newsholme, 'Domestic infection'.

17 McCleary, The Maternity and Child Welfare, 1-9; Newsholme, 'Infantile mortality', 489-95; Janet E. Lane-
together with the falling birth rate, would undermine British superiority in the international arena. Consequently infant welfare came to be seen as an essential part of the wider campaign which aimed at improving 'national efficiency', increasing industrial production, improving military competence and populating colonies. For the Germans, who were proud of their newly-acquired status as a world power, comparative statistics made even more depressing reading (See Figure 4.1.). Strategies were devised to reduce infant mortality and to improve 'national efficiency', or as they called it, 'Volkskraft'. The Nordic countries, on their part, were obsessed with catching up with the more 'advanced' industrial societies. They were eager to become 'civilized societies', 'kulturstater', and often borrowed foreign ideas without carefully analysing their benefits. In general, international rivalry and even wars seemed to be "good for babies."

![Figure 4.1. Infant mortality per 1,000 live births in Germany, France, England and Wales, and Sweden, 1875-1905](image)


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20 Plans to restrict women's industrial employment illustrates the point. The Swedish Parliament followed the example set by other European countries and passed a law in 1909 which prohibited women's night work in industry. Lynn Karlsson argues that the reform was "ill suited to the reality of the Swedish labor market" and it was opposed by both middle-class and working-class women. Lynn Karlsson, 'The beginning of a "masculine renaissance": the debate on the 1909 prohibition against women's night work in Sweden', in Ulla Wikander, Alice Kessler-Harris, and Jane Lewis (eds), *Protecting Women: Labor Legislation in Europe, the United States, and Australia, 1880-1920* (Urbana 1995), 235-66.
There is one apparent problem with this view. It does not recognize, let alone analyze, important political and social causes which the 'national efficiency' movement was deployed to advance. Nationalism pursuing narrow British or Swedish interests was seen as a perfectly legitimate aim and thus it became a convenient label under which other political and social objectives could be grouped. This study by no means seeks to deny the importance of national interests in motivating policy-makers to improve infant welfare. At the turn of the century, when economic and military rivalry was intensifying, concern about the physical condition of future generations as well as about their numbers was real enough. However, it is important to bear in mind that 'national efficiency', 'Volkskraft' and 'kulturstat' were also powerful catch-phrases that brought a wide constituency of support to health measures which were potentially very contentious.

The two legitimating strategies, the discourse of science and discourse of nationalism, in which infant welfare campaigns were grounded diverted attention away from political controversies. When policy-makers defined health problems as medical, technical questions, they lifted them from the political scene and were able to argue that the policies they pursued were above class antagonisms and gender conflicts. When they emphasized the importance of national interests in stimulating campaigns, they encouraged people to embrace the 'nation' as the most important context for self-definition and to relegate other categories, such as class and gender, which could also have provided a sense of identity.

Jane Lewis, Margaret Arnot and other feminist researchers who have examined infant welfare campaigns have shown some ways in which the debate about national interests and the discourses of medicine, social science and law served to legitimate gender inequalities. They argue that legislators, medical doctors and social reformers, both wittingly and unwittingly, reinforced gender hierarchies of power. On the other hand, these researchers have been criticized for being too dependent on the social control hypothesis. For example, John Macnicol argues that prime causal factors behind child welfare reforms were "more immediate considerations of economic management, class conflict, industrial efficiency and political strategy", not a desire to perpetuate gendered divisions of labour. The aim of this study is to discuss different objectives which shaped the infant welfare campaigns in Birmingham and Gothenburg and the ways in which scientific knowledge and national interests were used to reconcile and legitimate these often conflicting aims.

21 Gareth Stedman Jones argues that the theory of urban degeneration was "a mental landscape within which the middle class could recognize and articulate their own anxieties about urban existence." Gareth Stedman Jones, *Outcast London: A Study in the Relationship Between Classes in Victorian Society* (Oxford 1971), 151.

22 For political and social campaigns which the idea of national identity has been deployed to support, see Mary Poovey, 'Curing the 'social body' in 1832: James Phillips Kay and the Irish in Manchester', *Gender and History* 5 (1993), 196-211.

23 See, for example, Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939* (London 1980); Arnot, 'Infant death'; Smart, 'Disruptive bodies'.

By comparing the Birmingham and Gothenburg campaigns, it is possible to show the extent to which health authorities re-constructed scientific knowledge to suit wider political and social purposes. Although the Birmingham and Gothenburg authorities had access to the same body of medical knowledge, the Gothenburg authorities clearly 'knew' something which the Birmingham authorities did not know and vice versa. Some research findings which the Gothenburg authorities presented as hard facts were deemed as highly controversial in Birmingham and, on the other hand, some scientific results in which the Birmingham authorities grounded their policies were completely ignored by their Gothenburg counterparts. The systematic comparison also shows the complex political nature of 'national interests'. In serving the best interests of the nation, health authorities improved infant welfare, but they also defined the terms and conditions under which motherhood was deemed appropriate and they discriminated against women who did not embody 'the national virtues'.

The image of a healthy English society which the Birmingham campaign promoted could not accommodate immoral, unmarried mothers, whereas the Gothenburg campaign clearly discriminated against women who were ill, for example, those suffering from tuberculosis.

This chapter focuses, firstly, on the role which infant welfare campaigns played in regulating urban family life and family relations. It examines the process whereby two political ideals - the family's responsibility for self-support and the male breadwinner family model - became embedded in the 'apolitical' infant welfare campaigns, the explicit aim of which was to improve the well-being of infants. The Birmingham authorities managed to reconcile these three objectives. They proved 'scientifically' that the well-being of infants could be secured without direct economic assistance to the poorest families but that it could not be secured without the 'normal' family form. The Gothenburg authorities were unable, because of economic circumstances and cultural norms, to reconcile these objectives. Had they urged women to concentrate on their role as mothers, they should have provided economic assistance for the poorest families. The family's responsibility for self-support and the male breadwinner family model were, to an extent, irreconcilable objectives in Swedish society, and therefore the Gothenburg authorities had to choose between them. Hence the Gothenburg infant welfare campaign offers an interesting counterpoint to the Birmingham campaign. Secondly, the chapter discusses how the infant welfare campaigns created and maintained authoritative visions of the city. Health policies reflected the spatial arrangements of the cities and, perhaps more importantly, health authorities' views about the appropriate relationship between social classes and urban space. Political considerations of this type, and not for example the severity of the problem of infant mortality (see Figure 4.2.), explain the differences between the Birmingham and Gothenburg campaigns.

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Thirdly, this chapter explores how public health legacies and the interests of the medical profession affected the direction and form of the infant welfare campaigns. In Sweden the majority of medical doctors worked in the public sector and the expansion of publicly funded medical care was in their interests. In Birmingham, in contrast, general practitioners usually organized themselves against plans to develop public health services. These structural differences open opportunities to discuss the extent to which the needs of the mothers and children were defined in a way which served the interests of the medical profession.

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**DYFSFUNCTIONAL FAMILIES**

**TWO DEFINITIONS OF THE PROBLEM**

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**BIRMINGHAM**

For most of the nineteenth century, mortality league tables served to sustain Birmingham's reputation as a healthy manufacturing town and gave local policy-makers an excuse for ignoring important health and environmental issues. In the late 1890s, in contrast, these tables shattered Birmingham's good image and were the best weapon that the critics of the Health Committee could have.\(^{26}\) Firstly, the general death rate for Birmingham had not improved since the dramatic advances of the 1870s and early 1880s, and in

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\(^{26}\) J. A. Fallows, *The Housing of the Poor* (Birmingham 1899); Birmingham Public Record Office (BPRO), Birmingham Health Committee (HC), minutes 11.4.1899 item 5687; 23.4.1901 item 6766; 22.4.1902 items 7383-4. For the relative healthiness of Birmingham in the mid-nineteenth century, see for example Simon Szreter and Graham Mooney, 'Urbanization, mortality, and the standard of living debate: new estimates of the expectation of life at birth in nineteenth-century British cities', *Economic History Review* 51 (1998), 84-112.
consequence the city had lost the good position it had held among the large British towns. Secondly, an increase in infant deaths in the late 1890s shot Birmingham towards the top of the infant mortality league. Birmingham and Salford ranked highest in infant mortality of all major British cities in 1896 and 1897; a position that was rendered particularly unenviable by the enormous publicity which the question of infant welfare attracted at the time. The Birmingham authorities, in defence, argued that the death rates for the city were high mainly because 'healthy' middle-class families tended to live outside the municipal boundaries. However, at the turn of the century, when considerable agitation was underway to improve 'national efficiency' and to promote the health of the working class, excuses of this type rang hollow.

Admittedly, the Birmingham authorities were not alone in puzzling over the growing infant death rate. In many British cities infant mortality, and in particular mortality from diarrhoea, showed a slight increase in the last years of the century. In Birmingham, however, the upturn was sharp. Naomi Williams and Graham Mooney argue that the hot dry summers in the late 1890s represented a 'sanitary test' that exposed the towns "which had failed to secure safe public health through sound methods of environmental management" and in particular the towns which were "reliant on conservancy methods of excrement removal, such as privies and ash-closets." Birmingham, together with Sheffield and Salford, was among the first picked out by this test (Figures 4.2 and 4.3). Many contemporary observers drew the same conclusion as Williams and Mooney. The MOH for Birmingham, Dr. Alfred Hill, who was frustrated with the complacent attitude prevalent in the Health Committee and City Council, accused executives of not taking firm action to prevent diarrhoea epidemics. He conceived the dramatic increase in diarrhoeal mortality as being an index of environmental degradation and urged the Health Committee to press ahead with sanitary reform. Even more critical were local church leaders, investigative reporters and political opponents who bombarded the Committee with questions and complaints. The Committee responded by employing workmen to clean courtyards, by

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27 Annual Report for 1897, 3-10, 20-9; for 1898, 26-33; for 1899, 3, 10-1; for 1900, 10-1; Special Report on Infant Mortality, 6. The MOH compared 20 English and Welsh cities. In Scottish cities infant mortality was relatively low. R. A. Cage, 'Infant mortality rates and housing: twentieth century Glasgow', Scottish Economic and Social History 14 (1994), 78-80. For adverse publicity see Newsholme, 'Infantile mortality', 495-6.

28 In his annual reports, the new MOH, Dr. John Robertson, frequently made excuses of this kind. See, for example, Annual Report for 1906, 11-4; for 1907, 12-4; Charles Anthony Vince, History of the Corporation of Birmingham. Vol. III: 1885-1899 (Birmingham 1902), 125. See also Chapter 2, 35-7.


30 Annual Report for 1897, 3-10, 20-34; for 1898, 26-8.

31 BPRO, HC, minutes 11. 4. 1899 item 5687; 9. 5. 1899 item 5741a; 23. 4. 1901 item 6766; 9. 7. 1901 items 6901-2; 23. 7. 1901 items 6933 and 6935; 24. 9. 1901 item 6979; 22. 4. 1902 items 7383-4; 10. 6. 1902 item 7478. Annual Report for 1897, 30; Fallows, The Housing; Alan Mayne, The Imagined Slum: Newspaper Representation in Three Cities 1870-1914 (Leicester 1993), 78-93.
The average infant mortality rate for Birmingham for the ten-year period 1876-85 was 162. The rate for the period 1895-1905 was fourteen per cent higher, 185.

Sources: *Annual Report of the MOH for Birmingham for 1882*, 13; for 1888, 18; for 1906, 14.

Scientific legitimation for this approach was provided by the new MOH, Dr. John Robertson. Unlike Hill, who was an advocate of sanitary engineering throughout his career, Robertson had won his spurs as a bacteriologist and had learnt to think of sanitary reform as a relatively ineffective means of dealing with urban health problems. When he took over the job in 1903, the focus of policy shifted from the sanitary condition of the physical environment to the hygienic standards of the home. Robertson took a stance that, while there was no room for complacency in environmental management, measures which were exclusively aimed at cleaning up the city would not reduce infant mortality. Similar views were presented by the leaders of the national infant welfare movement such as Dr. George Newman, the then MOH for Finsbury. He argued that "(t)he future will lie with the State that is able to protect the individual against himself. And to do that it must build on the family life in the home, for the home is the unit of the State."34

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32 For the sanitary measures and health visitors, BPRO, HC, minutes 23. 7. 1901 item 6933; 9. 12. 1902 item 7774; 12. 1. 1904 item 8402; 8. 3. 1904 item 8517. *Annual Report for 1898*, 32-3; for 1899, 34-9; for 1901, 20.

33 *Special Report on Infant Mortality*, 4, 7. However, in some English towns sanitary measures seem to have been effective in reducing infant mortality. See Figure 4.3. and Hilary Marland, 'A pioneer in infant welfare: the Huddersfield scheme 1903-1920', *Social History of Medicine* 6 (1993), 44-50.

At the request of the Birmingham Health Committee, Robertson set out to investigate the problem of infant mortality during the first year of his tenure. His analysis of the problem and recommendations for reform were published in 1904 and distributed to all City Councillors and to the press. The plan which Robertson outlined in this report and which he, together with Doctors Jessie Duncan and Alexandra McCallum, developed further in later reports, formed a basis for the Birmingham infant welfare campaign. Robertson exerted considerable influence on decision-makers' thinking on these issues, but he played a key role even when his proposals were axed. When the Health Committee ignored his advice, the MOH distanced himself from the Committee's decisions or, perhaps more often, obliged the Committee by providing their decisions with scientific legitimation. To maintain his credibility the MOH categorically denied having yielded to political pressure and sought to give an impression that he himself had amended the proposals after considering them in the light of new or wider evidence. If a U-turn had to be made, the MOH sought to ensure it eroded his authority as an impartial expert as little as possible.

The impact of Robertson's reports was not limited to Birmingham. Some of his reports were drawn upon by Doctors George Newman and Arthur Newsholme and by other writers such as Janet Lane-Claypon. These health officials and writers were prime movers in constructing the national campaign and, through their discourse, defined problems and solutions. They recognized Robertson as an expert on questions concerning infant welfare and brought him into the national debate. On the other hand, Robertson associated himself with these opinion-forming circles and was careful not to contradict them. Indeed he went so far as to belittle the significance of his own research findings to bring his reports into line with the prevailing orthodoxy.

"Important" and "unimportant" causes of deaths

While Robertson acknowledged many causes of infant death, in practice he, as most British MOHs, equated infant mortality with the problem of infantile enteritis and diarrhoea. The discussion concentrated almost exclusively on these diseases which caused 15-25 per cent of infant deaths and was not broadened out to include other causes until the late 1910s. For example in 1904, Robertson contended that "almost all the other causes of infant deaths are comparatively unimportant." The narrow scope of the campaign was justified by defining deaths from diarrhoea as "easily preventable", while deaths from other causes were

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35 BPRO, HC, minutes 27. 10. 1903 item 8297; 28. 6. 1904 item 8732; 29. 11. 1904; 10. 1. 1905 item 9058. See also, Special Report on Infant Mortality. The Committee, which had just clashed with the City Council over housing policy, made a concerted effort to show that it was equal to this new challenge.

36 Newman, Infant Mortality, 189-196; Arthur Newsholme, 'Report on infant and child mortality', in 39th Annual Report of the Local Government Board (London 1909-10), Supplement, 57; Lane-Claypon, The Child Welfare, Appendix VII. Newsholm was the MOH for Brighton until 1908 and the CMO at the Local Government Board from 1908 to 1918. Lane-Claypon was a lecturer at the King's College for Women, University of London.

37 The deaths from diarrhoeal diseases constituted 33 per cent of infant deaths in 1899 and 15-25 per cent in the years 1900-05. Annual Report for 1906, 15. The quote is from Special Report on Infant Mortality, 14-5.
classified either as "preventable" or "non-preventable." Special measures against "preventable" causes, such as bronchitis and pneumonia which accounted for 15 per cent of deaths, were deemed unnecessary. The MOH argued that the campaign against diarrhoea would also serve to decrease deaths from respiratory diseases. However, the main reasons for his reluctance to suggest measures seemed to be that doctors knew little about these diseases and that even 'careful' mothers had difficulty in warding off attacks of bronchitis. A significant proportion of deaths from bronchitis occurred in respectable artisan or middle-class homes where children were presumably well taken care of and hence the MOH addressed the subject in discreet terms.

Dealing with prematurity and congenital malformations was even more difficult. These disorders, together with other 'wasting' diseases, caused 30-35 per cent of infant deaths, and they were great killers in both slums and suburbs. As the MOH discussed the question, his lack of enthusiasm was noticeable. Had he attributed the deaths, for example, to the quality of maternal care, he would have questioned the standard of practice of not only untrained midwives but also that of general practitioners who delivered middle-class women. In treading warily through this minefield, the MOH considered it wise to state that the deaths from prematurity and congenital anomalies "may not be preventable." The artificiality of these categories is revealed by the comparison between the Birmingham and Gothenburg campaigns. It was not uncommon for the Gothenburg authorities to place high on their agenda some causes of death which the Birmingham authorities defined as "unimportant." Furthermore, while the Gothenburg authorities sought to convey the message that basically all diseases would be preventable or curable if only taxpayers were willing to invest more money in medical care, the Birmingham authorities insisted that a large proportion of deaths were "non-preventable."

A filth disease

The Birmingham authorities were convinced that a pound spent in combating "easily preventable" diarrhoeal diseases would go much farther toward saving infant lives than a pound laid out in campaigning against other diseases. However, had poverty been allowed to emerge as the central issue, even the campaign against diarrhoeal diseases would have been costly, economically and politically. The MOH was aware of that and sought to avoid the pitfalls by reducing diarrhoea to "a filth disease" and by choosing his words carefully in defining the concept of filth. He often mentioned the problem of poverty, even analyzed possible impact of poverty on infant welfare, but at the same time he was careful not to talk himself into a corner. If need be, he went to great lengths to show that there was no direct connection between poverty and mortality. For


example, he argued that "mere size or even cheapness of house can in itself have little or no effect on the mortality", since in rural districts where people lived in simple two-roomed cottages infant mortality was rarely high. Similarly, low wages in themselves did not explain high rates of mortality among the babies of unskilled workers, since infant mortality among badly paid agricultural labourers was low. Alternatively, if the MOH admitted that poverty greatly decreased an infant's chance of survival, he emphasized that the main problem was secondary poverty which was due to thriftlessness and drinking. He was clearly careful not to raise false hopes of the municipality offering direct economic assistance to the poorest families.

The concept of filth was still broad in the first phase of the campaign and the blame for the existence of filth was placed, to an extent, on the whole community. Courtyards were sodden with filth mainly because the tenants did not clean them, but the landlords were not blameless either. They did not keep the yards in good repair. Homes in slum areas were dirty chiefly because the residents "were dirty in any conceivable way", but at the same time most houses were old and badly constructed. It was difficult to keep them clean. People's bodies and clothes were dirty because they were careless, but given the lack of washing facilities and hot water, little more in the way of personal hygiene could be expected of them. The accumulated dirt in houses and their immediate surroundings, the MOH argued, was the major cause of diarrhoea, and a concerted effort was to be made to deal with it. Municipal authorities, voluntary societies and private landlords were to give people a better chance of being clean and keeping their houses clean, but eventually the success of the campaign depended on whether the individuals improved their personal and domestic hygiene.

As Robertson examined defective housing and infant mortality, he took care to give his full support to the municipal housing policy. In considering different solutions to the inner-city housing problems, the Housing Committee, which was chaired by John Nettlefold, had decided to embark on a programme of piecemeal repairs instead of a large-scale slum clearance. The Committee sought to keep slum houses in a habitable condition by ordering owners to repair them and opened up courtyards to light and air by demolishing front and rear houses. When the MOH discussed the impact of defective housing on infant welfare, he concentrated on these factors: the structural defects of houses and the lack of air and sunshine. Hence he was able to conclude that, though living conditions in the central wards left much to be desired, the

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41 The quote from Special Report on Infant Mortality, 10. See also, Annual Report for 1906, 54; for 1910, 42; for 1914, 13-7. BPRO, Birmingham Public Health and Housing Committee (PH&HC), 26. 9. 1913 item 1695. An exception to this rule was the report, which was based on research done by Dr. Jessie Duncan. In this report, the MOH argued that poverty per se was an important cause of infant death. See, John Robertson, Report on Industrial Employment of Married Women and Infantile Mortality (Health Department, Birmingham 1910).

42 Special Report on Infant Mortality, 11-2; Report of the MOH on the Unhealthy Conditions in the Floodgate Street Area and the Municipal Wards of St. Mary, St. Stephen, and St. Bartholomew (Health Department, Birmingham 1904), 14-8.

43 Special Report on Infant Mortality, 11, 18-30; BPRO, HC minutes 29. 11. 1904 items 8995-9008; 10. 1. 1905 item 9050; 24. 1. 1905 item 9087; 14. 2. 1905 items 9115 and 9123.

44 Report on the Unhealthy Conditions, 23-5. See also, Mayne, The Imagined Slum, 85-93; Carl Chinn, Homes for People: 100 Years of Council Housing in Birmingham (Exeter 1991), 13-4.
most important problems were already being addressed. The Housing Committee was dealing with slum properties "in an energetic manner" and the progress was "satisfactory both as regards the houses themselves and as regards the amount of light and fresh air." The prevention of infant deaths in these "unhealthy areas", instead of requiring new housing initiatives, demanded changes in people's behaviour.45

This analysis met with a warm response. The local press, which had been more than ready to find fault with the health policy in the preceding years, did not contest the MOH's views.46 The City Council and the Health Committee, which consisted largely of manufacturers and businessmen, were also satisfied with the general tone of the reports and especially with the decision to relegate the problem of poverty somewhere down on the priority list. Most executives, regardless of party affiliation, continued to cling to the view that the municipality should not intervene in the economy of individual families. Furthermore, the executives seemed to agree with the MOH that unhealthy habits were the primary cause of infant deaths and therefore they were inclined to overlook the fact that some of his arguments lacked in both logic and cogency.47 Robertson based his analysis on an impressive selection of scientific findings but he frequently skated over difficulties in his deduction by using expressions such as "it is obvious that", "it is scarcely necessary to point out that." The discussion about mortality rates illustrates the point. Robertson produced detailed statistical evidence to confirm what was suspected all along: infant mortality varied markedly from ward to ward. Solely on the basis of this comparison, without providing a shred of new evidence, he jumped to the conclusion that these differences were largely due to personal failings of the people living in the unhealthy areas. He argued that "one cannot examine such a table without realising the fact that an enormous number of infant deaths ... arise from causes over which there must be control to a large extent by the parents."48

**Domestic disorder**

Although domestic and personal hygiene had been high on the agenda in the first decade of the century, the emphasis on individual responsibility was clearly at its strongest in the 1910s. The importance of medical care to the welfare of mothers and infants, which was to be stressed in the 1920s, did not yet figure

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45 Quotes from Special Report on Infant Mortality, 18, see also 11-2, 19-21; Report on the Unhealthy Conditions, 23-9.


47 BPRO, HC minutes 29. 11. 1904 items 8994-9008; 10. 1. 1905; 14. 2. 1905 item 9134 (HC's report to the CC, 32-8). See also the discussion about subsidized meals, BPRO, Birmingham Maternity and Child Welfare Sub-Committee (M&CWSC), minutes 7. 1. 1916 items 19-20; 4. 2. 1916 item 36; 3. 3. 1916 item 62; 2. 3. 1917 item 236; 4. 5. 1917 items 281-2; 5. 10. 1921 item 992 and doc. 2; Annual Report for 1914, 20-1. For discussion, see Lewis, The Politics of Motherhood, 13-21, 165-90; Pedersen, The Origins of the Welfare State, 32-59.

48 The quotes are from Special Report on Infant Mortality, 10, 12-3 (Italics - MN).
prominently in the discussion and on the other hand, the environmental issues, which had been considered as important in the first decade of the century, no longer attracted attention. The concept of filth had narrowed considerably by the 1910s. Although the MOH was acutely aware that slum houses were getting beyond repair, the problem of defective housing was now missing almost entirely from the discussion about infant mortality. Missing were also unpaved yards and poor sanitation. The message which the MOH sought to convey was that most infant deaths were a consequence of circumstances over which mothers had control, namely "dirty milk, dirty feeding bottles, dirty clothes, dirty floors and dirty comforters." A mother's ability to control domestic dirt was one element in the normative visions of maternity and family life which permeated gradually through the Birmingham campaign. The MOH had stressed the importance of mothering skills already in his first report in 1904, but from 1908 the competence of mothers and the cohesion of families came to be seen as the key explanatory variables in determining the level of infant mortality.

Feminist writers have shown that the British welfare state, compared with the French or Swedish one, developed along deeply gendered lines. The infant welfare movement was not an exception. The Birmingham campaign reflected and reinforced a normative model of the family in which men were assumed to be bread-winners and women were presumed to spend their time caring for their children and home. Securing as great a compliance as possible with this ideal was the central aim of the campaign.

As the MOH and other Birmingham health officials discussed mothering skills, a major portion of their message concerned feeding practices. This approach was justified by studies which showed that in poverty-stricken areas breast-fed babies stood a much fairer chance of survival than babies who were wholly or partially bottle-fed. If the infant welfare campaign was to succeed, then mothers, and in particular poor working-class mothers, had to be persuaded to continue breast-feeding until their children were nine months old. The task ahead seemed big. The MOH presumed, at least initially, that a significant number of poor mothers in Birmingham weaned their children prematurely because of ignorance or carelessness. Although the overriding concern was to discourage mothers from bottle-feeding, health officials often broadened the discussion out to include other 'abnormal' family relations. The MOH emphasized that in 'problem' homes, where mothers did not look after the household cleanliness, even breast-fed babies came into contact with "fatal" dirt. Furthermore, an Assistant MOH, Dr. Jessie Duncan, showed that breast-feeding did not guarantee the well-being of the infant if the mother was malnourished. Malnutrition, in turn, was often


ascribed to the lack of solidarity in 'problem' families. Husbands spent a large proportion of their income on drink, while their wives and children suffered acute deprivation. What exacerbated the situation was poor household management. In particular, the MOH criticized working-class mothers for their lack of cooking skills: "the catering and the cookery for the household" was often "as bad as it well can be." He also stated that any improvement in the standards of housekeeping seemed remote, since working-class girls "employ(ed) themselves in low grade factory labour" instead of preparing themselves for their future role as mothers.  

_Milk, dirt and disease_

The Birmingham authorities knew very well that premature weaning could not always be ascribed to ignorance or carelessness. A survey of 486 mothers who bottle-fed their babies showed that no less than 22 per cent of these mothers had been advised to give up breast-feeding by their family doctor. A further 62 per cent of mothers claimed that they had an insufficient amount of breast-milk, and both midwives and medical doctors were ready to confirm that in most cases this was true. Prompted by this survey, Robertson urged the Health Committee to do everything in its power to ensure that mothers who were unable to breast-feed could obtain clean milk for their babies. He predicted in 1904 that mortality among artificially fed babies would decline only marginally, if the Committee confined its activities to educational measures and ignored ill-health caused by dirty milk.  

The Committee, which had praised the MOH for giving new insights into the importance of domestic hygiene and mothering skills, was not particularly impressed with the way in which he linked the problems of milk supply with infant mortality. The Committee agreed with the MOH that an important reason why a large number of artificially fed babies suffered from diarrhoeal infections was that the cow's milk which was given to them was contaminated with dirt and disease. However, the question of who was to blame for the contamination and what measures should be taken to solve the problem did not encourage similar consensus. In this matter, Robertson lost the initiative and was left with the thankless task of providing scientific legitimation for the policy which the Committee was determined to pursue.

The proposals which the MOH put forward in 1904 were couched in explicit acknowledgement that the quality of milk sold in the city, and in particular in the central wards, was poor. The MOH clearly took the view that ignorant as working-class mothers were, they were not solely responsible for the contamination of milk. Cow's milk was often infected before it reached the customer because of the insanitary conditions

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54 For the survey which was conducted in 1903, see _Annual Report for 1905_, 21-3. See also Marks, _Metropolitan Maternity_, 107-11. For MOH's recommendations, see _Special Report on Infant Mortality_, 21-9.

55 BPRO, HC minutes 29. 11. 1904 and in particular items 9002-5; 10. 1. 1905 items 9050-2; 24. 1. 1905 item 9091; 14. 2. 1905 items 9120 and 9134; 14. 3. 1905 item 9173; 11. 7. 1905 item 9390; 12. 3. 1907 item 424; 25. 6. 1907 item 628.
under which it was produced, transported and sold. Robertson recommended that Health Committee deal with the problem by inspecting cowsheds and milkshops, by controlling the bacteriological quality of milk and by advising people how to store milk in the home. Secondly, to ensure a clean milk supply for infants the Committee should establish milk depots, where sterilized milk would be sold at a cost within the reach of the working class.\textsuperscript{56} However, Robertson soon changed his mind, bringing his statements into line with the views of the Health Committee and of pre-eminent public health officials such as Arthur Newsholme. In 1906 Robertson relegated milk to a minor role, and in a handbill which was distributed to homes in 1911 he stated that "milk does not carry the disease into the home, although it may be contaminated at the home." The bottle-fed babies were exposed to death only because their mothers did not "understand the need for regularity and extreme cleanliness in artificial feeding of babies."\textsuperscript{57} It would be a total waste of money to provide clean milk for these infants, since milk would quickly become contaminated in the home.

The inconsistencies in Robertson's reports were clear. In his earlier writings he blamed farmers, wholesale dealers and retailers for the contamination of milk, then later he argued that the problem was entirely due to uncleanliness in the home. Similarly, while he first favoured milk depots, in later contributions he pulled back after 'finding out' that there was not enough scientific evidence to support the measure. Many present-day researchers argue that early twentieth-century health authorities were far too optimistic in pinning their hopes on health education. Valerie Fildes contends that in the poorest areas of London the campaigns to persuade mothers to breast-feed were unnecessary. The incidence of breast-feeding was high and "probably could not have been improved upon."\textsuperscript{58} This seemed to be the case also in Birmingham. Furthermore, the MOH's argument that "milk does not carry the disease into the home" was certainly too optimistic. Although Birmingham was active in improving the quality of milk, the measures taken in Birmingham and other cities were not adequate. Peter Atkins shows that in the 1920s "(t)he conditions of milk production were still disgracefully filthy and ill-regulated, with those of transport and sale only marginally better."\textsuperscript{59}

Factory mothers

Concentration on the ignorance and fecklessness of mothers demonstrates clearly that the Birmingham health authorities were concerned with finding ways of regulating urban family life and family relations. Even more

\textsuperscript{56} Special Report on Infant Mortality, 16, 21-9.


\textsuperscript{59} P. J. Atkins, 'White poison? The social consequences of milk consumption, 1850-1930', Social History of Medicine 5 (1992), 207-27. For plans to improve the quality of milk in Birmingham, see for example, John Robertson, 'Prevention of tuberculosis among cattle', Public Health 22 (1909), 324-8.
revealing, however, is the early twentieth-century discussion about infant mortality and married women's industrial employment. This debate shows that the determination to buttress the conventional family and its hierarchy of roles could override other important considerations including the well-being of children. It also reveals how strong the pressure for uniformity of opinion was among public health experts, when the discussion turned to the bedrock principles of society.

The view that female employment predisposed society to high levels of infant mortality was by no means new. The debate on the question had been rumbling along in the pages of medical journals and governmental reports since Edwin Chadwick had published his classic *Report on the Sanitary Condition of the Labouring Population* in 1842. The argument which was set out in this report and reiterated in countless other reports in the course of the nineteenth century was that female employment in general and married women's factory work in particular were irrational, immoral and unhealthy.60 At the turn of the twentieth century, the debate gained momentum again. Many public health experts, and especially Doctors George Newman and George Reid (the MOH for Staffordshire), managed to make a name for themselves with studies which 'proved' that there was a clear causal link between infant mortality and the occupation of mothers outside the home.61

These studies failed to provide conclusive evidence of the relationship between infant mortality and women's employment.62 However, by combining discourses of medicine and social statistics with melodramatic narratives of neglected homes, they went a long way towards convincing health experts and executives that factory mothers were to blame for the high rates of infant mortality.63 Decision-makers seemed to speak on the problem with one voice. Firstly, they pointed out that only a small proportion of factory mothers were able to combine their work with intensive breast-feeding. Secondly, working mothers rarely made proper provision for their children's care during the day, and those who did exposed their children to bronchitis by carrying them out to a childminder in the early morning. Thirdly, it was argued that factory mothers were

60 For a summary of nineteenth-century studies of the subject, see May Tennant, 'Infantile mortality', in Gertrude M. Tuckwell et al., *Woman in Industry: From Seven Points of View* (London 1908), 87-119; Newman, *Infant Mortality*, 90-138. In Chadwick's report, physicians argued that in Birmingham 'the habit of manufacturing life' was being "established" in many girls and that these girls often continued to work after getting married. She "leaves her home and children to the care of a neighbour or of a hired child, sometimes only a few years older than her own children, whose services cost her probably as much as she obtains for her labour. To this neglect on the part of their parents is to be traced the death of many children." Edwin Chadwick, *Report on the Sanitary Condition of the Labouring Population of Great Britain*. Edited by M. W. Flinn (Edinburgh 1965), 205-6.


62 For the present-day analysis of the studies, see for example, Wohl, *Endangered Lives*, 25-32; Graham, 'Female employment', 313-7; Dyhouse, 'Working-class mothers'.

63 For example, Newman, *Infant Mortality*, 90-138; Tennant, 'Infantile mortality'.
particular ignorant and that it was difficult to instruct them in infant care. During the day she was at work and "when the evening comes she is too tired and too busy to welcome the teaching of the Health Visitor."

Unsurprisingly, the question of how to deal with the problems which mothers' employment caused proved to be more controversial. Some social reformers and health experts insisted that mothers of young children, or all married women if possible, should be barred from working in industry. Legal restrictions were necessary, since factory mothers were clearly unwilling to meet the standards of behaviour laid down by enlightened experts. The Birmingham MOH was not among these reformers. He took a view that, although married women's employment was inimical to infant welfare, some mothers desperately needed their earnings. Municipal authorities should strongly discourage mothers from seeking paid employment outside the home but it would probably be unwise to prohibit mothers from working. However, this issue was clearly problematic for the MOH and other health officials in Birmingham. Time and again they had to consider whether they were ready to break from prevailing orthodoxies and ask awkward questions.

The problems arose when the Birmingham officials started investigating the issue after the National Conference on Infant Mortality which was held in 1906. The conference, where local authorities were strongly represented, recommended that central government extend compulsory (unpaid) maternity leave to three months and legislate that mothers would be allowed to return to work after the leave only if they produced satisfactory evidence that proper provision had been made for the care of their children. The Home Office responded by asking local authorities to acquire further information as to the industrial employment of married women and infant mortality. The Birmingham Health Department embarked on a series of investigations in 1907 and produced several reports on the question during the years 1908-12.

Against all expectations, the study which was conducted in 1908 revealed that in the poorest areas of the city mortality among the babies whose mothers worked in factories or were engaged in charring or washing was considerably lower than among babies whose mothers were not employed. In 1910 and 1911 mortality was

64 Tennant, 'Infantile mortality', 89-90, 117-9, the quote from page 90; Newman, Infant Mortality, 90-138. For Birmingham see Annual Report for 1906, 17-20; Robertson, Report on Industrial Employment, 16-7, 20-2; BPRO, M&CWSC, minutes 7. 7. 1916 item 112.

65 Tennant, 'Infantile mortality', 90.

66 In his report in 1904 Robertson even suggested that municipal authorities should help mothers combine work with motherhood by providing day nurseries. See, Special Report on Infant Mortality, 30. In his later writings, he took the view that the municipal authorities should discourage women from working outside the home. Annual Report for 1905, 23; for 1906, 16-20; Robertson, Report on Industrial Employment.


68 BPRO, HC, minutes 28. 5. 1907 item 575; Robertson, Report on Industrial Employment; Jessie Duncan, Report on Infant Mortality in St. George's and St. Stephen's Wards (Health Department, Birmingham 1911); idem, Report on the Prevention of Infantile Mortality; Annual Reports for 1908-1912.
again lower among the children of working mothers (Table 4.1). These investigations suggested that in the inner-city areas poverty was a far more important contributory factor to infant deaths than women’s employment. The MOH admitted to being perplexed by the results. His instincts said that the children of working mothers were at a distinct disadvantage, but the studies conducted by his department pointed in the opposite direction. The conclusion he drew from the studies was a kind of compromise. He claimed that

**Table 4.1. Infant mortality and mother’s employment in St. Stephen’s and St. George’s Wards in Birmingham, 1908 - 1912**

<table>
<thead>
<tr>
<th>Mother</th>
<th>1908</th>
<th>1909</th>
<th>1910</th>
<th>1911</th>
<th>1912</th>
</tr>
</thead>
<tbody>
<tr>
<td>employed</td>
<td>190</td>
<td>179</td>
<td>153</td>
<td>191</td>
<td>191</td>
</tr>
<tr>
<td>not employed</td>
<td>207</td>
<td>169</td>
<td>161</td>
<td>192</td>
<td>174</td>
</tr>
</tbody>
</table>


women’s employment had a detrimental effect on infant welfare, but in the inner-city areas poverty served to mask this influence. He was not alone in belittling these research findings. Arthur Newsholme, the Chief Medical Officer at the Local Government Board, stated that it would be sheer folly to infer from these kind of studies "that the industrial occupation of mothers is not a most injurious element in our social life." However, Duncan was arguing from the sideline. The official view was that if the campaign was to succeed, women had to be encouraged to concentrate on their role as mothers. For example, when the delegates of the Birmingham Health Department, including the MOH John Robertson, returned from the Fourth English Speaking Conference on Infant Mortality in 1913, they stressed that the largest obstacles to improving infant welfare were maternal ignorance, factory work and venereal diseases. Poverty and the lack of medical care were not mentioned.

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69 See in particular, Robertson, *Report on Industrial Employment*.


72 BPRO, PH&HC, minutes 26. 9. 1913 item 1695. See also minutes 22. 3. 1912 item 352.
What makes this case particularly interesting is that the Birmingham authorities knew all along - before conducting any investigations - that working mothers were not to blame for the high rates of infant mortality. For example, in the summer 1906, almost 700 infants died in the central wards and only in 39 of these cases (6%) did the mother work outside the home. No one in the Birmingham Health Department expected that the campaign against women's work as such would dramatically improve infant welfare. They hoped that it would bring other tangible benefits. By linking infant mortality with working mothers, authorities conveyed the message that the conventional middle-class family with its bread-winning husband and dependent wife was the 'natural' and, by definition, the best family model. This approach was approved of not only by most middle-class people but also, for example, by male trade unionists who feared that cheap female labour would serve to undercut wages. Yet there was one aim which was more important than buttressing the conventional gender roles. If municipal authorities had to decide whether they provided economic assistance for desperately poor mothers or 'allowed' these mothers to work, they chose the lesser of two evils: they allowed the mothers to work. In the early twentieth century, the principle that families should be economically independent overrode the wishes to encourage 'normal' domestic relations. In most cases, however, the Birmingham authorities did not have to choose but were able to construct policies which reflected and reinforced both these ideals. In Gothenburg combining the ideals proved difficult.

GOTHENBURG

Like Birmingham, Gothenburg failed the 'sanitary test' in the 1890s. Policy-makers in Gothenburg had responded promptly to perceived community needs for a safe water supply and an effective sewer system, but the technologies which they had employed in addressing these needs failed to adapt to the changing standards of hygiene and to long-term pressures of growth. For example, in the early 1890s it was realized that the conversion to water closets was not possible until the sewerage system had been upgraded and modernized. Policy-makers, reluctant to commit money to the improvements of the sewerage infrastructure, shelved plans to introduce water closets and only began really to deal with the matter in the early twentieth century. A penalty for the reliance on traditional methods was paid in the late 1890s, when the hot and dry summers brought significant increases in infant mortality (Figure 4.2, page 82). However, even in the 1890s, Gothenburg had much lower rates of mortality than those found for other large Swedish towns (Figure 4.4).

73 Annual Report for 1906, 17. For bottle-feeding and women's employment, see Annual Report for 1905, 23.


75 Lindman, Dödligheten, 126-7; Årsberättelse för 1906, 38; Ola Wetterberg and Gunilla Axelsson, Smutsguld och dödligt hot: Renhållning och återvinning i Göteborg 1864-1930 (Göteborg 1995), 123-69, 210; Artur Attman, Göteborgs Stadsfullmäktige 1863-1962. Vol. 1.1: Göteborg 1863-1913 (Göteborg 1963), 343-7 and Vol. 1.2: Göteborg 1913-1962 (Göteborg 1963), 274-5. For the infant death rate in the late 1890s, see Årsberättelser för 1895-1900. See also Figure 4.2, page 82.
Dr. Carl Lindman, whose study of infant mortality in Sweden was published in 1898, pointed out that Gothenburg was well ahead of Stockholm, Malmö and Norrköping in combating the problem. Moreover, studies comparing infant mortality rates in different European countries showed Sweden in general and Gothenburg in particular in a favourable light.

Relatively good infant health in Gothenburg was attributed to the sanitary reforms which the city had carried through. The increase in infant mortality in the 1890s served as a valuable reminder that there was still room for improvement in environmental management, but on the whole the new sanitary services seemed to have made Gothenburg a much healthier place to live. The general mortality rate had decreased considerably.
REGULATING FAMILY LIFE

in the late nineteenth century, and a decline in infant mortality in the 1880s had corresponded with the timing of important sanitary reforms. In particular, the re-organization of the waste collection system in 1885 seemed to have reduced infant mortality dramatically (See Figure 4.2, page 82). Hence while the Birmingham authorities concluded that sanitary measures improved infant welfare only marginally, their counterparts in Gothenburg were convinced that the well-being of infants depended largely on the money and ingenuity which were invested in environmental sanitation.

Against this background one might have expected environmental questions to play an important part in the Gothenburg infant welfare campaign in the early twentieth century. However, in constructing the campaign the Gothenburg authorities relegated defective sanitation, bad housing and domestic dirt down on the priority list. The authorities by no means denied that these factors had an impact on infant mortality. Working-class areas in Gothenburg may not have been 'slums' in the British sense of the word, but there were enough insalubrious neighbourhoods and insanitary courtyards in the city to cause serious concern. Habits of cleanliness in Gothenburg may have been different from those in Birmingham, but in both places domestic dirt posed a danger to infant health. Yet the Gothenburg authorities were convinced that dealing directly with these factors was not the most promising avenue. By analyzing how the Gothenburg authorities defined the problem of infant mortality, the following sections show that the Gothenburg authorities' decision to relegate environmental problems and domestic dirt was as logical (or illogical) as the Birmingham authorities' decision to overemphasize these factors. Despite the fact that these campaigns were clearly shaped by political and social concerns, they both could be defended, to an extent, as scientific and rational.

"Important" and "unimportant" causes of death

Although the Gothenburg authorities paid much attention to the prevention of infantile diarrhoea, this disease did not dominate the discussion. Other causes of infant death such as congenital defects, bronchitis and pneumonia also figured prominently in the Gothenburg campaign from an early date. All these diseases and disorders took a heavy toll on infants' lives. At the turn of the century, diarrhoeal diseases were the greatest killers of infants in Gothenburg, accounting for 30 per cent of deaths. However, by 1910 the proportion of diarrhoeal deaths had declined to 18 per cent and, as a major cause of infant death, diarrhoea was now far exceeded by other diseases and disorders. Prematurity and congenital defects were responsible for 30 per cent of deaths, and respiratory diseases such as bronchitis and pneumonia for 25 per cent. Comparing these cause-of-death tables with those of Birmingham is problematic. Infant deaths were often poorly diagnosed,


80 Årsberättelser för 1890-1910; Lindman, Dödligheten, 120-4; Brodin, 'Spådbarnsdödligheten', 3664-6.
and some descriptions such as prematurity were ambiguous. However, it is possible to say that the comparison of these tables does not provide any clues about the reasons why the Birmingham authorities concentrated on preventing infantile diarrhoea and why the Gothenburg authorities launched a broader campaign. The proportion of diarrhoeal deaths in Gothenburg seemed to be as high as in Birmingham, if not higher.

The main reason why the Gothenburg campaign covered a broad spectrum of diseases was that the Health Committee was inclined to emphasize the medical aspects of the problem. It is not difficult to understand why this was the case. In the early twentieth century, medical doctors comprised 30 per cent of the Health Committee members in Gothenburg, and other professionals such as architects, engineers and lawyers were also strongly represented in the Committee. This awesome group of experts was by no means averse to exploiting its position and in consequence many health problems became defined as technical matters which were to be resolved by professionals on the basis of scientific criteria. The fact that medical doctors knew little about congenital defects and bronchitis was not an insurmountable obstacle to campaigning against these diseases; after all, the authority of doctors was not based on their capacity to prevent and cure illnesses. In Gothenburg, the doctors who were involved in the construction of public health policy as elected or appointed officials enjoyed a relatively high status in society. Their competence was not questioned, even though the policies they pursued did not always bring immediate dividends. In Birmingham, the status of appointed health officials was lower and therefore they were constantly under pressure to show results.

Furthermore, the Gothenburg Health Committee was able to develop municipal services without a fear that every measure they took would be scrutinized and criticized by independent practitioners. More often than not, the Swedish medical profession campaigned in unison for the expansion of publicly funded medical care. The majority of doctors worked in the public sector and benefited directly from public investments in health care, but even doctors who did not hold a public post were acutely aware of the importance of municipal involvement. Central and local governments were the only agencies in Sweden which were capable of providing the infrastructure for the expansion of modern medicine and for the development of new specialities such as paediatrics and obstetrics. In Birmingham it was a very different story. The Birmingham Health Committee was constantly being reminded not to 'encroach' into the territory of the independent practitioner. In an attempt to conciliate the critics, the Committee and the MOH emphasized that the Public Health Department concentrated exclusively on 'preventive medicine' and left treatment to general practitioners.

81 Årberettelser för 1900-16; för 1917-20, Del I and II. What further consolidated the power of the medical profession in the Gothenburg Health Committee was that the chairman was always a doctor. In Birmingham, in contrast, doctors comprised only 0-13 per cent of the Health Committee members in the early twentieth century, with the exception of the years 1908-10, when their proportion was higher, at 25 per cent.

82 See Chapter 1, 8-15; Chapter 3.

Since local government funding was crucial for the medical establishment in Gothenburg, one can appreciate the eagerness of doctors to define health problems as technical matters. However, the trade was not all one way. The desire to accommodate the medical profession was not the only reason why the City Council committed resources to medical care. Making medical services more widely available was an aim which had overwhelmingly positive resonance for most Councillors in Gothenburg. Firstly, this aim was in line with the traditions. Although Swedish health authorities had failed to deliver in the nineteenth century, in theory they had been responsible for providing medical care for acutely ill patients. Accordingly, in the early twentieth century the debate did not centre on the question of whether authorities were responsible for providing hospital beds for babies with life-threatening bronchitis or diarrhoea. The controversial question was when the municipality could afford to provide services of this type. Secondly, the medical approach was popular, since it lacked sensitivity to the context in which patients had fallen ill. By emphasizing the role of medical doctors, policy-makers kept the problem of disease prevention in laboratories, clinics and hospitals, and managed to avoid discussing the social causes of diseases such as defective housing and poverty.

The nature of the sources on which this study is based highlights the differences between the Gothenburg and Birmingham campaigns. The sources shedding light on the Gothenburg campaign reflect the fact that infant mortality was often accepted as a technical question. In their reports, the First City Physician and hospital consultants, who were the prime movers in constructing the Gothenburg campaign, usually concentrated on the technicalities of health care. Highly publicized investigations, which played a key role in legitimating policies in Birmingham, were not considered necessary. Furthermore, the process whereby infant welfare emerged as a distinct public health question in Gothenburg was slow. The nineteenth-century sanitary measures which had reduced the general mortality rate seemed to have had a similar positive effect on infant mortality. Hence early twentieth-century authorities in Gothenburg did not see any cause to examine the problem of infant mortality in isolation; on the contrary, the prevention of infantile diarrhoea and bronchitis was often perceived as a part of the wider campaigns against diarrhoeal and respiratory diseases.

A medical problem

In Gothenburg, many commentators who expressed anxiety about the physical welfare of children demanded the extension and modernization of hospital facilities. This campaign, the principal spokesman for which was the consultant surgeon of the children's hospital, Dr. Gustaf Bergendal, attracted influential support from public health officials, politicians and philanthropic dignitaries. The scarcity of medical resources, they

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84 The comparison between Göteborgs hälsovårdnämnds årsberättelser (Annual Reports of the Gothenburg Health Committee) and Annual Reports of the MOH for Birmingham illustrates the point. While the First City Physician for Gothenburg concentrated on the technicalities of health care and environmental sanitation, the MOH sought to convince his readers about the effectiveness of the chosen policies and to sell them on new ideas.

argued, was an important contributing factor to the high rates of infant mortality and to the prevalence of ill-health among children. Firstly, a large number of infants and small children whose illnesses were completely curable were condemned to death or disability because of the lack of medical care. Secondly, chronic illnesses and disabilities restricted many children's everyday life more than was necessary, since these children did not have access to effective treatment. The campaigners claimed that many infants with diarrhoea or pneumonia would benefit from hospital care and that effective therapies were available to relieve and rehabilitate children suffering from congenital defects or non-pulmonary tuberculosis. The well-being of children could be vastly improved if only there were enough specialists and clinical facilities in the city.86

In the early years of the twentieth century, the only hospital in Gothenburg which admitted children under six years of age was the Children's hospital. This institution, though voluntarily run, was dependent on the municipality for financial support, and the board of the hospital had been answerable to the City Council since 1869.87 In the early twentieth century, the campaigners pointed out to the City Councillors that donations no longer kept up with the growth of the population and with the demand for technologically intensive medical care. It was time for the municipality to commit more resources to the hospital. The main daily newspaper, *Göteborgs Handels- och Sjöfarts-Tidning*, which was sympathetic to the cause, praised the excellent work done in the hospital and bemoaned overcrowding and lack of facilities for patients.88 Another problem, often pointed out by the campaigners, was that the admission patterns of the hospital were thoroughly outmoded: children from well-to-do homes and infants under two years of age were not admitted. In a modern hospital, the campaigners contended, diagnosis rather than the social location of the patient should be the key to admission. Hence the children's hospital should provide treatment for all sick children irrespective of their social background and age. However, effective treatments could be made accessible to more children and the international standing of the Swedish paediatrics could be secured only if the hospital budget was augmented by various forms of municipal support.89

The importance attached to the medical approach in Gothenburg is further illustrated by the turn-of-the-century debate about maternity care. A municipal committee, which was set up in 1896 to consider the improvement of maternity provision, took the stance that a modern maternity hospital was an essential part

86 For the discussion about children's access to medical care, see GSH 1903:122A, No. 7; 1903:122B, No. 14; 1903:196, 15-9 and 50-6 (this table demonstrates clearly the increasing importance attached to children's health care); 'Göteborgs barnsjukhus', *Göteborgs Handels- och Sjöfarts-Tidning (GH&ST)* 24.11. 1903; GSH 1908:102, 156 and minutes 17. 9. 1908 item 11; 1910:269 and minutes 8. 12. 1910 item 11; 1910:272; 1917:39. See also, Isberg, 'Barnavård', 69; Sven Johansson, 'Göteborgs barnsjukhus' historia', *Hygiea* 84 (1922), 454-67; Lars Öberg, *Göteborgs Läkaresällskap: En historik* (Göteborg 1983), 223.

87 Johansson, 'Göteborgs barnsjukhus' historia'.

88 See for example, 'Göteborgs barnsjukhus', *GH&ST* 24. 11. 1903.

of municipal health care services in towns such as Gothenburg which had a population of over 100,000.\textsuperscript{90} What was essential in Gothenburg was not necessarily essential in Birmingham. The Birmingham policy-makers were convinced that their city with the population of 500,000 managed well with a small number of maternity beds provided by the poor law authorities and voluntary hospitals.\textsuperscript{91}

Medical doctors were in the front line of campaigning for the hospitalization of childbirth in Gothenburg. Many doctors took for granted that extensive provision of maternity beds would reduce both infant and maternal mortality, and in the light of the empirical evidence which was available, it was impossible to prove or disprove their assumption. For example, it was impossible to determine the relative safety of hospital deliveries versus home deliveries, since difficult maternity cases were usually admitted to hospitals. Doctors were fully aware that drawing firm conclusions about the safety of hospital deliveries was difficult and therefore they usually referred to the question indirectly. Instead of proving that hospital deliveries were safer than home deliveries, they 'showed' that childbirth was safer in the Gothenburg maternity hospital than in many other European hospitals. For example, they argued that neonatal mortality among babies born in the Gothenburg hospital was much lower than among babies born in famous French and German institutions. The impression of scientific accuracy was created by presenting statistical information on the work of the Gothenburg hospital and by comparing mortality rates for the Gothenburg hospital with the rates for some other European institutions. Disparity in mortality rates between hospitals was attributed to the effectiveness of medical care in Gothenburg. Other possible contributory factors such as the social background of mothers were ignored.\textsuperscript{92}

The stance taken by the medical profession attracted support from mothers and, to an extent, from policy-makers.\textsuperscript{93} Many mothers sought in-patient maternity care because anaesthesia was more readily available in hospitals and because they appreciated post-natal care which hospitals offered. Another explanation for the popularity of hospital deliveries was overcrowding and poor housing conditions in working-class areas. Mothers could not get adequate rest after the childbirth in homes where a family shared one or two rooms. Policy-makers, though somewhat reluctant to invest large sums of money in a new municipal maternity hospital, agreed that small flats were inappropriate settings for childbirth. Furthermore, many policy-makers saw hospitalization as a way in which to manage the housing problem. When maternity cases and patients

\textsuperscript{90} Abraham Westman, 'Bamböödsanstaltens historia' in \textit{Årsberättelse för 1900}, appendix.

\textsuperscript{91} J. Ernest Jones, \textit{History of Hospitals and Other Charities of Birmingham} (Birmingham 1909), 55-8.


\textsuperscript{93} For the demand for maternity beds in Gothenburg, see Westman, 'Barnbördsanstaltens historia'. 4. See also Vallgårda, 'Hospitalization of deliveries', 188-90; Marks, \textit{Metropolitan Maternity}, 209-14; Lewis, \textit{The Politics of Motherhood}, 117-39.

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who were suffering from tuberculosis or other infectious diseases were removed from overcrowded homes to hospitals, it was easier for policy-makers to postpone the serious discussion about housing reform.94

*Milk as 'medicine'*

The Gothenburg campaign was strongly influenced by the French infant welfare movement and in particular by the baby clinics and milk depots which had been established in Paris and Normandy in the 1890s.95 The influence of the French innovations manifested itself especially in the debate about infant feeding. While the Birmingham authorities took a principled stand, consistently emphasizing the value of breast-feeding, the Gothenburg authorities chose a more flexible approach. The First City Physician, Karl Gezelius, and other doctors who campaigned for milk depots by no means belittled the benefits which a mother's milk offered. Breast-feeding clearly gave an infant the best possible start in life, especially in working-class areas where sanitary provisions left much to be desired. Furthermore, these doctors did not make light of the popular supposition that the incidence of artificial feeding was rising. Poor urban mothers increasingly seemed to experience difficulties in breast-feeding. They worked outside the home, they had an insufficient amount of breast-milk or they were just "unwilling" to nurse their children. Gezelius and his colleagues wanted to see this trend reversed and suggested that voluntary societies instruct mothers in infant care and, if need be, help them maintain breast-feeding by providing modest economic assistance in the form of food and cash. However, if these measures failed and a medical doctor confirmed that the infant could not be fed wholly on breast-milk, voluntary and municipal agencies should ensure that pure cow's milk was available. Hence while Gezelius extolled the benefits of breast-feeding, he seemed to do so less loudly and less insistently than did the Birmingham MOH.96

The approach which Gezelius chose was not without opposition. Some medical doctors and social reformers argued that by giving his support to milk depots, the First City Physician had sanctioned artificial feeding and encouraged women to leave the home.97 However, the Health Committee and City Council placed more weight on the evidence which Gezelius presented than on the evidence produced by his critics. The

94 For further discussion about hospitalization and housing, see Chapter 5.

95 Höjer, 'Mjölkdroppar', 44. See also, Weiner, 'De "olydiga" mödrama'.

96 Gezelius and other doctors who were involved in establishing milk depots defended their stance in 1909-11, when the City Council decided to allocate funds to this activity. The majority of depots in Gothenburg were run by a voluntary society, Föreningen Mjölkdroppen, which had been founded at the instigation of Gezelius in 1903. Furthermore, Gezelius was the chairman of the society from 1903 to 1908. See GSH 1909:252, 3-5, 11-14, 25-6 and minutes 7. 1. 1910 item 6; 1910:59; 1911:27; in particular 3-9. See also 'K. J. Gezelius' in Magnus Fahl, Göteborgs Stadsfullmäktige 1863-1962. II: Biografisk Matrikel (Göteborg 1963). For the growing acceptance of artificial infant feeding, see, Rima D. Apple, "Advertising by our loving friends": the infant formula industry and the creation of new pharmaceutical markets, 1870-1910, History of Medicine and Allied Sciences 41 (1986), 3-23.

97 Carlberg, 'Frivilligt arbete', 540; GSH 1909-252 and minutes 7. 1. 1910 item 6. See also GSH 1926:192 and minutes 12. 5. 1926 item 24. See also, Isak Jundell, 'Kvinnomjölken och komjölken opsoniner', Hygiea 74 (1912), 335-45.
Gothenburg authorities generally took the stance that the responsibility for prevention of diarrhoeal diseases among artificially fed babies was shared among municipal authorities, voluntary societies and mothers. This approach was based on the explicit acknowledgement that the milk which was sold in the city was often highly contaminated. Municipal authorities were, firstly, to intensify their efforts to control the conditions of milk production and handling and, secondly, to supervise a few chosen farms which produced milk especially for small children. However, these measures alone would not solve the problem, since the milk which came from the special farms was too expensive for many families. Here voluntary societies entered the picture. Most policy-makers viewed the issue of municipal assistance to families with ambivalence but they accepted the idea that a voluntary society, possibly with municipal support, provided free or subsidized milk for the poorest children. Finally, since mothers were often ignorant of the principles of hygiene, they should be advised as how to store and prepare milk. Artificial feeding, the authorities argued, could be safe if prepared in the right conditions. This was the prevailing orthodoxy in Gothenburg until the mid 1920s.

In seeking to reduce mortality among artificially fed babies in the early twentieth century, the Gothenburg authorities emphasized experts’ control over disease. Medical doctors were involved with improving the bacteriological quality of milk, and they supervised the care of all artificially fed babies who attended the milk depots. In each case, they ascertained that the reason for premature weaning had been ‘acceptable’ and decided how milk should be modified. Hence, cow’s milk which was given to infants in the milk depots was a form of ‘medical treatment’ for which particular diagnosis was necessary. The Gothenburg authorities clearly emphasized the medical questions in improving infant welfare, even though they were ready to admit that there were also important social causes to infant deaths.

Irresponsible parents

Instilling a sense of responsibility in mothers was an aim which the Gothenburg and Birmingham authorities shared. Yet the associations evoked by this aim were dissimilar. The Birmingham authorities stressed the importance of full-time motherhood to the well-being of children, and working mothers were denounced in no uncertain terms. The policy was fully justified, so it was argued, by studies which showed that married women’s employment was an important contributing factor to infant deaths. The Gothenburg authorities, though admitting that a too hasty return to work by new mothers was inadvisable, did not consider maternal occupation as such to be inimical to infant welfare. They took the view that both fathers and mothers were responsible for maintaining their children and that parents who evaded this responsibility were largely to

98 See for example, Arberätelse för 1910, 20-6.

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blame for the high infant death rates.\textsuperscript{100} Unsurprisingly, the Gothenburg authorities usually ignored the studies which linked infant mortality with mothers' work.\textsuperscript{101}

In Gothenburg the sharpest criticism was levelled at women who concealed their motherhood. Until 1917, mothers who gave their newborn babies away could remain anonymous, if they chose. A survey which was conducted in Gothenburg in 1912 showed that approximately 80 unmarried mothers exercised this right annually. The vast majority of them sought care within private maternity homes, and midwives who delivered them also arranged for their children to be placed in foster homes or orphanages.\textsuperscript{102} In discussing different ways in which infant and child welfare could be improved, the Gothenburg authorities paid attention to the extreme vulnerability of these deserted children. Almost without exception they were bottle-fed and therefore exposed to diarrhoeal diseases, but many of them were wilfully neglected and abused as well. The authorities did not criticize the "unknown" mothers for giving their children away; on the contrary, they seemed to think that many illegitimate children were better off fostered or adopted, without their natural parents. What concerned the authorities was, firstly, that mothers who remained anonymous could easily evade their responsibility for maintaining their children, which meant that many of these children eventually ended up in the care of poor law authorities. Secondly, it was difficult for the authorities to control foster care arrangements made by "unknown" mothers. The health authorities demanded an amendment to the law which allowed mothers to remain "unknown."\textsuperscript{103}

The vast majority of unmarried mothers, about 90 per cent, did not exercise the right to remain anonymous. However, the health authorities were quick to point out that this was of little comfort, as long as their powers to 'protect' illegitimate children were inadequate. Most Swedish studies of infant mortality in the late nineteenth and early twentieth centuries paid special attention to illegitimacy as a reason for the high infant death rates. Whereas the British authorities examined variation in infant mortality rates between salubrious suburbs and insanitary slums, the Swedish authorities concentrated on comparing the death rates for illegitimate and legitimate infants. For example, a study published in 1871 revealed that while mortality among legitimate infants in Gothenburg was 164 per thousand live births, mortality among illegitimate

\textsuperscript{100} See for example, GSH 1909:252, 11, 29; 1912:18; 1917:284.


\textsuperscript{102} GSH 1912:18, 16-9.

\textsuperscript{103} GSH 1912:18; 1912:273 and minutes 31. 10. 1912 item 8. See also, Elizabeth Elgán, 'Le législateur au secours de la mère célibataire: la solution de la responsabilité individuelle', in Marie C. Nelson and John Rogers (eds), Mother, Father, and Child: Swedish Social Policy in the Early Twentieth Century (Uppsala 1990), 55-67.
REGULATING FAMILY LIFE

Infants was 289 - meaning that almost one-third of illegitimate babies died before their first birthday. By the early twentieth century, infant death rates had declined considerably but the gap between the two groups had not narrowed. The mortality rate for legitimate infants was about 64 in the years 1908-12, and the rate for illegitimate babies was 127. In setting out to 'protect' illegitimate children, Swedish health officials and social reformers had to take into account that unmarried mothers were a large and visible minority, not a small stigmatized group. Punitive measures, favoured by many British authorities, were out of the question. Hence the Gothenburg authorities sought to construct policies which enhanced the life chances of unmarried mothers and their children but which also provided the authorities with means of controlling the mothers.

The health authorities concluded that unmarried mothers' ignorance and carelessness were major reasons for high mortality among illegitimate babies. However, it is evident that 'ignorance' had a somewhat different meaning in the Gothenburg and Birmingham campaigns. The Gothenburg authorities were less concerned with mothers' lack of knowledge about the safe methods of infant care and more with their inability to protect their children's interests. Firstly, the health authorities argued that unmarried mothers often handed their children over to unscrupulous foster mothers who exposed the infants to death and disease. Since many midwives, who arranged for the children to be placed, and foster mothers were clearly unreliable and profited shamelessly at the expense of illegitimate children, municipal authorities were to step in. Public health and poor law officials who investigated the question recommended that the City Council establish a child welfare office which would arrange for illegitimate children to be placed in good foster homes. Secondly, the health authorities were fully aware that many single mothers who did not give their children away were too poor to look after them properly. The main problem, the authorities argued, was that ignorant and inexperienced mothers did not make an effort to gain legal recognition of the paternity and economic assistance from the fathers. Prompted by the desire to keep unmarried mothers and their children off public funds, the health and poor law authorities recommended that the City Council provide legal advice for mothers. Nonsupporting fathers were not be tolerated. Furthermore, to help single mothers reconcile motherhood with paid work and to prevent them from moving to prostitution, the City Council should support day nurseries. Unmarried motherhood was a social problem in which many threatening themes - mortality, immorality and economic dependence - intersected and therefore solving the problem required not only the expert knowledge of medical doctors but also that of child welfare officers and lawyers.

104 J. Hellstenius, 'Dödligheten inom första lefnadsåret, i Stockholm och i Göteborg', Statistisk Tidskrift 2 (1871), 120-6.


106 For unscrupulous foster parents, see Årsberättelse för 1906, 2; för 1907, 2; Göteborgs stadsarkiv (GSA), Göteborgs Hälsovårdnämnd, I avdelningen (HVN I), minutes 23. 3. 1917 item 58; 4. 4. 1917 item 61. For the official definition of the problem, see GSH 1912:18; 1912:273; 1917:109; 1917:284.

107 GSH 1909:252; 1912:18; 1912:273. See also, Jan Gröndahl, 'Single mothers and poor relief in a Swedish industrial town (Gävle) at the beginning of the twentieth century', and Elgán, 'Le législateur au secours de la mère célibataire', in Nelson and Rogers (eds), Mother, Father, and Child, 31-53 and 55-67.
Although the authorities were quick to link infant mortality with unmarried motherhood, the problem was by no means restricted to the children of "unknown" and unmarried mothers. Both legitimate and illegitimate infants whose families were living in poverty were exposed to fatal diseases. The Gothenburg authorities were acutely aware of a close association between poverty and infant mortality, but they were ready to deal with the poverty problem only by indirect means, by supporting nurseries and milk depots, by providing legal advice and by regulating foster placements. The central aim of these measures was to help, or force, parents to provide for their children and therefore to restrict the burden imposed on the rate-payers.

Different views

A campaign which encouraged poor married and unmarried mothers to work outside the home was not likely to provoke a storm of criticism in Gothenburg. Textile and food processing industries were concerned to employ female labour, and male trade unionists did not fear women's competition for jobs, since the labour market was thoroughly sex-segregated. However, there were a number of social reformers and paediatricians in Gothenburg and in Sweden in general who criticized the public health and poor law authorities for belittling the importance of the duties and responsibilities of motherhood. In particular, these reformers were astonished by the authorities' eagerness to help unmarried mothers place their newborn babies in foster homes. The critics argued that instead of breaking the mother-child bond, the authorities should encourage the maternal element. The well-known Swedish paediatrician, Isak Jundell, called for reforms which would make it more difficult for unmarried mothers to hand their babies over to foster mothers. The public health authorities should teach unmarried mothers a lesson by insisting on all mothers raising their own children, at least until their children had reached one year of age. Jundell recommended that voluntary and municipal agencies establish 'homes' where unmarried mothers could stay as long as they breast-fed their children. Moreover, Jundell argued that nonsupporting fathers should be sentenced to hard labour. Tough measures were necessary, since some fathers were even ready to emigrate to America to evade maintaining their children.

Middle-class women who participated in the debate, criticized the continuing double standard in which men's sexual experiences outside marriage were accepted or excused while women's were condemned. Although they often emphasized that unmarried mothers needed moral guidance, they levelled the sharpest criticism at the fathers of illegitimate children. Frigga Carlberg, a prominent campaigner for women's rights, accused men of having created a "women and children proletariat" condemned to poverty and starvation. What the

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108 For poverty and infant mortality, see for example, Lindman, Dödligheten, 20-3; Jundell, 'Moderskydd', 52.


110 Carlberg, 'Frivilligt arbete'. See also GSH 1917:284; 1918:228.
health authorities and their critics agreed over was that more active official intervention in the family life was necessary to protect the interests of children and the interests of society.\textsuperscript{111} The next section examines briefly the ways in which the ideas of infant welfare were implemented in Gothenburg and Birmingham.

--- EXPERTS, MOTHERS AND INFANTS ---

**BIRMINGHAM**

Convinced that the solution to infant mortality lay in the education of mothers, the Birmingham Health Committee concentrated on developing the health visiting scheme. The first municipal visitors had been appointed in 1899, and in 1907 the visiting scheme had a staff of fourteen. In this phase of the campaign, when insanitary environment and domestic dirt were regarded as the major culprits in causing infant deaths, the majority of health visitors were working-class women who had a rudimentary grasp of the principles of hygiene. They worked mainly in the "unhealthy areas", instructing poor mothers on domestic hygiene and infant care.\textsuperscript{112} The MOH praised the excellent work of the visitors, but the scheme was also criticized, for example, by poor law medical officers. In his statement to the Royal Commission on the Poor Laws in 1907, Dr Bycott from Deritend doubted whether the health visitors had effected any improvement in the attitudes and habits of the poor in Birmingham: "I do not hear them much quoted by mothers." He urged the Health Department to employ "a better class of women" and preferably trained nurses.\textsuperscript{113}

*Health visiting and infant consultations*

The Health Committee, though satisfied with the concept of health visiting, admitted that the existing arrangements were not accomplishing all that was wished. The Committee decided to upgrade the infant welfare scheme by employing experts and by introducing new services in the problem areas. In 1908, a "lady doctor" was appointed to work with two "experienced" health visitors in St. George's and St. Stephen's

\textsuperscript{111} GSH 1911:27, in particular 8-9; 1912:18; 1917:109; 1917:284; 1917:295; Carlberg, 'Frivilligt arbete'; 'Kvinnokongressen i Stockholm', Ny Tid 7 and 8. 8. 1908; Almquist, Allmän hälsovårdslära, 792-4; Isberg, 'Barnavård'; idem, 'De öka baren'. See also, Ann-Sofie Ohlander, 'The invisible child? The struggle for a Social Democratic family policy in Sweden, 1900-1960s' in Bock and Thane (eds), Maternity and Gender Policies, 60-72; idem, 'Das vergessene Kind? Der Streit um die sozialdemokratische Familienpolitik', in Nelson and Rogers (eds), Mother, Father, and Child (Uppsala 1990), 7-30; Ohrlander, 1 barnens och nationens intresse.

\textsuperscript{112} BPRO, HC, minutes 14. 2. 1899 item 5559; 28. 3. 1899 item 5667; 25. 7. 1899 item 5896; 24. 7. 1900 item 6418; 9. 10. 1900 item 6469 & 6470; 26. 3. 1907 item 474. Annual Report for 1899, 34-9, for 1900, 28-33, for 1901, 22-4; for 1902, 33-5. See also, Celia Davies, 'The health visitor as mother's friend: a women's place in public health, 1900-14', Social History of Medicine 1 (1988), 45-7.

\textsuperscript{113} Royal Commission on the Poor Laws and Relief of Distress, 1909. Appendix. Volume IV, Questions 43 998 (26); 44 590-44 603.
Wards, where traditional health visiting had not succeeded in reducing infant mortality. Dr. Jessie Duncan and the two health visitors specialized in infant welfare work, visiting the homes of new-born babies every week for the first five weeks and then every month. Furthermore, they organised "infant consultations", where mothers were instructed in infant care and babies were weighed and examined. The focus of the campaign had clearly shifted from domestic hygiene to mothering skills. What facilitated the reforming of the campaign was the passage of the 1907 Notification of Births Act, which obliged the father to notify the MOH of the birth within 36 hours. This Act enabled health visitors to instruct mothers before "much harm (had) been done."114

Duncan reported to the Health Committee that the infant consultations had proved the most important part of her work, since mothers were "in a better condition to receive information" when they came to the clinic than they were in their own homes. The clear indication of the success, she argued, was that careless and drunken women and even mothers of illegitimate children attended consultations. Assured of the potential of the new service, the Health Committee decided in 1912 to form three new special areas into which infant consultations and systematic home visiting of infants were introduced. Moreover, infant welfare work undertaken by voluntary societies supplemented the municipal services. The societies formed their own special areas and employed doctors and health visitors, sharing both the aims and methods of the municipal campaign. All visiting and consultation services were educational. Anxious to accommodate independent medical practitioners, the Public Health Department stuck to its principle of concentrating on preventive medicine. Hence doctors who worked for the infant consultation clinics did not provide any medical treatment but referred cases of illness to family doctors or voluntary hospitals. Furthermore, economic assistance in the form of meals or milk was not made widely available on the grounds that measures of this type threatened to usurp the husband's responsibility to maintain his family. In the winter of 1917 the Health Department provided a subsidized meal for approximately 20 pregnant or nursing mothers per day, and in 1923 the average daily attendance was 140 mothers. The provison was limited, given that about 16,000 babies were born in the city annually.118


115 The quote is from BPRO, HC, minutes 10. 12. 1907 item 853. See also HC, minutes 14. 1. 1908 item 893 and 896; *Annual Report for 1906*, 19-20; *for 1907, 17*; *for 1910, 10-1.*


117 BPRO, PH&HC, minutes 8. 3. 1912 item 311; 22. 3. 1912 item 364; 24. 10. 1913 item 1785; 10. 9. 1914 item 2602; 9. 10. 1914 item 2687; 12. 11. 1914 item 2785; 8. 12. 1916 item 4154; 13. 7. 1917 item 4395; *Report of the MOH on Child Welfare in 1913*, see in particular Chart F; 'Report of the MOH on maternity and child welfare during 1916'. See also, Birmingham Infants' Health Society, *Annual Reports for 1908-18.*

118 For medical care, see BPRO, PH&HC, minutes 24. 10. 1913 item 1785; M&CWSC, 7. 1. 1916 item 19: 4. 2. 1916 item 36; 'Report of the MOH on maternity and child welfare during 1916'. 1. For meals, see BPRO, M&CWSC, minutes 4. 2. 1916 item 36 and 36a; 3. 3. 1916 item 62; 2. 3. 1917 item 236; 4. 5. 1917 items 281-2; 4. 5. 1921 item 942; 5. 10. 1921 items 991-2. *Annual Report for 1914, 20-1; for 1923, 55.*
Health visiting and in particular infant consultation clinics, which gradually developed into infant welfare centres, occupied the most prominent place in the Birmingham campaign even in the 1920s and 1930s. The network of health visitors and "lady doctors" who worked among mothers and young children was determinedly developed until the mid-1920s and the provision was very good. In 1927, no less than 90 per cent of all babies born in Birmingham were visited by a health visitor and 75 per cent of babies attended an infant welfare centre at least once.119 In 1934, when the Local Government Board recommended that local authorities appoint one health visitor per 250-280 births, Birmingham had one visitor per 140 births.120

Unhealthy and healthy areas

In the first phase of the campaign, the Birmingham authorities had paid their attention almost exclusively to the "unhealthy areas" in the centre of the city. By 1910, however, some of the optimism with which the special campaign had been launched in these problem areas had vanished. The "ignorance and carelessness" of mothers had not evaporated as easily as health officials had wished to believe. Consequently, the tone of the reports of the leading health officials changed in the early 1910s. In his report in 1910, the MOH John Robertson flirted with the idea of taking legal action against tenants who persisted in keeping their houses in filthy condition: "If persons who are so neglectful as to allow filth to exist were punished in one way or another, it is almost certain that some of the mortality in these areas would be reduced, and possibly some of the poverty."121 The assistant MOH, Dr. Alexandra McCallum was also pessimistic. She reported that it was very difficult to induce the poorest mothers "to do anything with care and regularity."122 The people living in the central wards were increasingly presented as unteachable pathological underclass.

With hindsight, it is easy to explain the poor results of the campaign in the central wards. The Birmingham health authorities, as most advocates of the lifestyle theory of disease, ignored the unequal abilities of people to change their habits. However, the Birmingham authorities did not stop to think about possible reasons for the poor results, they just turned their attention from the slum areas to the working-class suburbs. In 1913, the MOH argued that the best results from infant welfare centres would be "obtained among the artisan classes rather than among the slum dwellers" and he urged the Committee to establish "up-to-date institutions" in respectable working-class areas.123 The trend became more noticeable in the 1920s and

119 BPRO, Birmingham Maternity and Child Welfare Committee (hereafter M&CWC), minutes 11. 3. 1927 item 1432.
120 BPRO, M&CWSC, minutes 4. 10. 1918 item 505; Annual Report for 1933, Lewis, The Politics of Motherhood, 106; Marks, Metropolitan Maternity, 172.
121 Annual Report for 1910, 14.
122 BPRO, PH&HC, minutes 24. 10. 1913 item 1785.
1930s, when the Birmingham authorities concentrated on introducing infant welfare services into the new council estates. Municipal services were increasingly aimed at the 'respectable' working class and lower middle class which were important groups politically. Furthermore, the new estates were fertile ground for the dissemination of modern child care ideas. While in the slum areas women often turned to their mothers and neighbours for advice, in the new estates most women were isolated from their old neighbours and relatives. The authorities could easily attach them to 'acceptable' collectivities such as mothers' clubs.¹²⁴

Full-time motherhood

Although the vast majority of mothers even in the central wards of the city stayed at home, the number of women who combined paid work with motherhood was by no means small. Yet the infant welfare campaign was firmly based on the conventional family pattern. The campaign was designed to help full-time mothers and to strengthen their commitment to motherhood and, in consequence, working mothers rarely benefited from municipal services. On the contrary, infant welfare measures often placed an additional burden on women whose familial situation was not in keeping with the normative roles. In Birmingham the families of working mothers were labelled as problem families and their every-day life was kept under closer scrutiny than that of other poor families. Furthermore, since factory work was considered to be particularly inimical to infant welfare, the authorities tended to recommend "factory mothers" to leave their jobs and to undertake some form of domestic labour instead. This type of work was easier to combine with childcare, but it was poorly paid and, in many cases, even more exhausting than factory work.¹²⁵ While the municipal authorities made it more difficult for mothers to work outside the home, the Home Office took steps to restrict their work opportunities at home. The government department expressed concern about homeworkers' low wages, their poor working conditions and the problem that some women "seriously ill-use their children and ... keep them away from school."¹²⁶ Though new regulations to control homework were motivated by a desire to protect homeworkers and their children, in practice these regulations often added to the hardships many women and children already suffered by depriving them of an important survival strategy.

The Birmingham health authorities did not provide nurseries, milk depots or any other services which would have helped mothers reconcile paid work outside the home with childcare. Consequently, in making provision for their children's care during the day, working mothers had to turn to neighbours, friends and grandparents for help. A 1906 survey of the babies of 771 working mothers showed that 51 per cent of the

¹²⁴ BPRO, M&CWSC, minutes 3. 3. 1926 item 1800; 29. 2. 1928 item 2185; 28. 3. 1928 item 2215; M&CWC, minutes 12. 3. 1926 item 1307; 11. 3. 1927 item 1432; 9. 3. 1928 item 1603. See also, Catherine Hall, 'Married women at home in Birmingham in the 1920's and 1930's', Oral History 5 (1977), 62-83.

¹²⁵ Annual Report for 1906, 17-9; Robertson, Report on Industrial Employment; Duncan, Report on Infant Mortality, 7. See also, BPRO, M&CWSC, minutes, 7. 1. 1916 item 19.

¹²⁶ BPRO, HC, minutes 11. 12. 1906 item 260.
infants were cared for by a neighbour, and 13 per cent by a relative living in a neighbouring house. Approximately 35 per cent of the infants were looked after in their own homes by an adult, often the grandmother or another relative, and only one out of 771 babies was taken care of at a (voluntary) nursery. The MOH was convinced that municipal nursery provision would have induced married women to leave the home: "(i)f good, clean crèches were everywhere available I think this would be an inducement to married women with families of young children to leave the infants at the officially recognised crèche and go to work." In many European countries, the MOH admitted, nurseries were an important part of the infant welfare schemes, but in England, where the illegitimacy rate was low, establishing nurseries would be inadvisable. Illegitimacy, mothers' employment and nurseries were clearly seen as 'foreign' phenomena.

The Health Committee's decision not to establish milk depots was contested several times. In 1907, the City Council drew the Committee's attention to the good results which milk depots had brought about in other towns and instructed the Committee to take the question into consideration. In 1912, a group of inhabitants of Duddeston and Nechells wards called on the Committee to establish milk depots. The Committee replied that they did not "feel justified" in recommending the measure. They claimed that the results of milk depots often appeared very good, since only careful parents used the milk from these depots, while "the ignorant and careless parents (did) not go near them." Supervision of midwives

The Birmingham authorities did not show much interest in maternity care before the First World War. To implement the 1902 Midwives' Act, which obliged local authorities to supervise midwives and to notify Central Midwives Board of serious cases of malpractice and negligence, the Health Committee had appointed a midwife inspector in 1904. She was fully occupied, since in Birmingham, where midwives attended 65 per cent of all births, midwifery standards were low. In 1906, 90 per cent of certified midwives practising in Birmingham were untrained, whereas in Manchester the percentage was 35 and in Liverpool and London only 10. Moreover, about 30 per cent of the Birmingham midwives were illiterate and could not take a patient's temperature. Voluntary hospitals took some measures to train midwives, but the change was slow to come. In 1916, 66 per cent of midwives were still untrained. Provision of hospital beds for maternity cases was

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128 BPRO, PH&HC, minutes 8. 3. 1912 item 312; 22. 3. 1912 item 352. During the First World War municipal nurseries were established for children whose mothers were engaged in munition works, but this was a war emergency measure not an attempt to broaden the infant welfare policy. BPRO, PH&HC, minutes 8. 12. 1916 item 4154.

129 BPRO, HC, minutes 12. 3. 1907 item 424; 25. 6. 1907 item 628; PH&HC, minutes 8. 3. 1912 item 337; 22. 3. 1912, the report of the PH Sub-Committee and item 364.

130 BPRO, HC, minutes 9. 12. 1902 items 7782 and 7784; 11. 3. 1903 item 7946; 27. 10. 1903 item 8278; 28. 9. 1904 item 8842; 13. 12. 1904 items 9025 and 9029; 14. 2. 1905 item 9134; 11. 7. 1905 item 9411; 12.
not considered to be within the compass of municipal responsibilities. The first exception to this rule was the Health Committee's decision in 1911 to provide economic assistance for a voluntary hospital which set aside a few beds for puerperal fever patients. The exception was made on the grounds that independent medical practitioners objected "to attend (puerperal fever) cases that occur in the practice of midwives."131

**New interpretations**

In reappraising their strategy in 1916, the Birmingham health authorities began to consider the possibility of improving mothers and infants' access to medical care. Three members of the Birmingham Maternity and Child Welfare Sub-Committee were sent to acquaint themselves with the infant welfare programmes of London, Liverpool, Manchester and Bradford. This tour served to confirm what had been suspected: The Birmingham campaign, and especially the medical resources for infants and mothers, left much to be desired. The Sub-Committee members were particularly impressed by the infant welfare provision in Bradford. Apart from infant consultations, the Bradford Health Department ran a milk depot and two hospitals for infants. Municipal maternity services were far more wide-ranging than those in Birmingham, consisting of an antenatal clinic, municipal midwives and a maternity hospital with a modern operating room and an ambulance. Meals were supplied for pregnant and nursing mothers, and children's clothes were sold at cost price. Moreover, the Bradford Health Committee was seeking powers to compel factory owners to establish nurseries. Inspired by the Bradford scheme and prompted by the wartime preoccupations with military strength, the Birmingham Committee started developing their infant welfare scheme further.132

The new proposals submitted to the City Council were couched with the explicit acknowledgement that the campaign which had concentrated on combating diarrhoeal diseases had not come close to solving the problem of infant mortality. In particular, the MOH drew policy-makers' attention to the high rates of neo-natal mortality. Traditional services such as home visiting and infant consultations had not been effective in reducing mortality among newborn babies and therefore these services should be supplemented by other measures.133 The MOH, who had emphasized the importance of preventive medicine for fifteen years, became a strong advocate of publicly funded hospital services. In 1918, he argued that voluntary hospitals which were entirely dependent on the generosity of the charitable could not answer to the needs of the city.


131 BPRO, HC, minutes 10. 1. 1911 item 2809; 14. 2. 1911 item 2877; 24. 5. 1912 item 518.


133 BPRO, M&CWSC, minutes 4. 1. 1918 item 386.
Consequently, in their report to the City Council in 1920, the MOH and the Health Committee suggested that 100 hospital beds would be provided for infants with 'wasting diseases' or rickets and that an emergency hospital would be set up every summer for infants suffering from diarrhoea.134

The debate over maternal health centred on the prevention of maternal deaths. For the health authorities, who wanted to encourage women to have large families, the high rates of maternal mortality presented a problem. In 1918, the MOH admitted that "(c)hildbirth, while undoubtedly a normal physiological process, is attended by real danger to both mother and infant." This danger "can, and should be, successfully met by the application in every case of the best known methods of modern scientific practice."135 The Health Committee suggested that the midwifery service should be made more attractive to "well trained and capable women" by securing them a sufficient remuneration. Moreover, the Committee would provide 60 maternity beds by establishing maternity homes and 100 beds by making a contract with a voluntary hospital. A medical officer was to be appointed so that women who could not afford to see a general practitioner would have an opportunity to consult a doctor before the childbirth. In order to give mothers a break from household chores during the lying-in period the Committee would provide home helps at reduced fee.136

What facilitated the expansion of the work was the 1918 Maternity and Child Welfare Act and other wartime reforms which conferred new powers to local authorities and made 50% government grants available to them for the support of infant and maternal welfare services. However, the efforts to implement the plans were hampered by the recession in the early 1920s. The development of ante-natal care was one of the few plans which were not shelved during the years of financial stringency. The ante-natal services had two purposes. Firstly, pregnant women were advised as to how to take care of their own health, and secondly, they were examined by a doctor. As a result of the scheme, 35 per cent of women who were confined in Birmingham in 1926 had been seen by a doctor at one of the infant welfare centres before confinement.137 The implementation of the other plans was slower. In 1921, only 30 beds were reserved for babies suffering from wasting diseases and in 1932, the number of beds was still below 100. In the mid-1920s, when pressures were mounting on maternity beds, the Health Committee started co-operating with the poor law authorities to improve the maternity provision in the city. This arrangement, which meant that "Council cases" - 'respectable' working-class women - had to share hospital facilities with "Poor law cases", was strongly criticized by some Health Committee members.138

134 BPRO, M&CWSC, minutes 4. 2. 1916 item 36; 4. 10. 1918 item 505; M&CWC, minutes 23. 4. 1920 item 580.
135 BPRO, M&CWSC, minutes 5. 7. 1918 item 493; M&CWC, minutes 23. 4. 1920 item 580.
136 BPRO, M&CWC, minutes 23. 4. 1920 item 580.
137 BPRO, M&CWC, minutes 11. 3. 1927 item 1432 and document 11.
138 BPRO, M&CWSC, minutes 5. 10. 1921 item 991-2; 1. 10. 1924 item 1524; 3. 12. 1924 item 1553; M&CWC, minutes 14. 11. 1924 item 1157; 9. 1. 1925 item 1159; 13. 2. 1925 item 1165; 8. 5. 1925 item 1205; 9. 12. 1927 item 1525. Annual Report for 1932, 116.
Although the policy-makers were fully aware that many of their plans had not been carried through, it came as a surprise to them in the late 1920s that no headway had been made in reducing neo-natal mortality and maternal mortality. The hope that ante-natal consultations would have been effective in improving the well-being of mothers and infants proved too optimistic: Maternal mortality appeared to have been rising in the 1920s and the decline in neo-natal mortality had been small. When the City Council urged the Health Committee to rethink its strategies, the Committee responded by laying some of the blame on mothers. A large proportion of mothers did not attend ante-natal consultations and many of those who did failed to follow the instructions given by doctors. However, the Committee was ready to admit that there was also room for improvement in medical services. The new MOH, Dr. H. P. Newsholme, recommended that the Health Department introduce post-natal examinations to "safeguard mothers' health in relation to future pregnancies" and provide more hospital beds for maternity cases and premature babies. Again, some of these plans could not be implemented, since municipal spending had to be cut in the early 1930s.

Although the Birmingham health authorities regarded financial difficulties as the major obstacle in improving health care provision, there were also other factors which hampered the development of services. In Birmingham, medical services were a battleground, where all parties - independent practitioners, voluntary hospitals and municipal authorities - claimed to be acting in the best interest of the patient. The independent practitioners organized themselves into an effective pressure group which successfully campaigned against public health authorities' plans to offer free medical treatment. They argued that municipal health care services interfered in the relationship between the patient and her trusted family doctor. Municipal health officials, who were more self-confident in the 1920s than they had been in the early twentieth century, responded that many working-class women could not afford to consult a general practitioner. The exact location of boundaries between the private and public health care remained a source of controversy in Birmingham throughout the period reviewed here.

**GOTHENBURG**

In the Gothenburg campaign, health education was clearly a lesser priority in the early twentieth century. Instead of instructing mothers in infant care and domestic hygiene, voluntary and municipal agencies concentrated on running milk depots and nurseries and on providing medical care for mothers and infants. The most important reforms, in economic terms, were the modernization and extensions of maternity and children's hospitals. The hospital boom in Gothenburg in the early twentieth century was not an isolated case but part of the national pattern of hospital development. In many Swedish towns, municipal authorities

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139 BPRO, M&CWSC, minutes 28. 3. 1928 item 2218; 2. 5. 1928 item 2232 and document 27.

committed resources to improving mothers and children's access to technologically intensive medical care. However, Gothenburg and Stockholm clearly set the trend.141

Hospitals and clinics

The Gothenburg Children’s hospital, which had begun as a philanthropic institution, was gradually taken over by the municipality in the first decade of the twentieth century. Pushing the reform through was not difficult. While the proposal to build a municipal tuberculosis sanatorium provoked a bitter dispute in the City Council, the plan to assist in rebuilding the children's hospital was unanimously approved.142 The Council invested 100,000 crowns in a project for providing a larger building for the institution, and when the new hospital was opened in 1909, it was financed from public revenue. With the public funding, the old image of the children's hospital as a charitable institution serving only the poor was replaced by a new image as a centre of scientific medicine functioning for the community at large. The hospital, which had both medical and surgical departments and a special department for infants, was extended several times in the 1910s.143 The new building of the municipal maternity hospital, which was opened in 1900 and extended as early as 1906, encouraged the hospitalisation of childbirth. While in 1899 'only' 25 per cent of women in Gothenburg went into the maternity hospital to have a baby, in 1918 50 per cent of all the births took place in the hospital and in the 1930s 85 per cent. These figures suggest that in Gothenburg the hospitalization of childbirth was strongly promoted by politicians and medical doctors and widely supported by mothers. In Birmingham, the percentage of births taking place in hospital was much lower, even though the number of maternity beds in poor law infirmaries, voluntary hospitals and private maternity homes was on increase. Only 6 per cent of deliveries took place in institutions in 1917, and 33 per cent in 1935.144

In addition to the new children's hospital which provided medical treatment on an in-patient and out-patient basis, milk depots improved infants' access to medical care. The milk depots were run by a voluntary society, Föreningen Mjölkdroppen, but they were designed to supplement municipal services. This was

141 For maternity hospitals and children's hospitals in Sweden, see Wolfram Kock, 'Lasaretten och den slutna kroppssjukvården', and Justus Ström, 'Den förebyggande barnavården', in Wolfram Kock (ed.), Medicinalsasendet i Sverige 1813-1962 (Stockholm 1963), 188 and 528; Vallgårda, 'Hospitalization of deliveries'.


143 GSH 1903:196 and minutes 3. 10. 1903 item 2; 1910:269; Årsberättelse för 1919, II del, 28-9; Johansson, 'Göteborgs barnsjukhus' historia'.

144 For Gothenburg, see Walter, 'Barnbärodhusets i Göteborg verksamhet', 13; Statistisk årsbok för Göteborg för 1900, 44; Brodin, 'Spådbarnsdödligheten', 3662; Westman, 'Barnbördsanstaltens historia'; Attman, Göteborg 1863-1913, 334-5. For Birmingham, BPRO, M&CWC, minutes 23. 4. 1920 item 580, 3; Lewis, Politics of Motherhood, 121.
hardly surprising, given that the society had been established at the instigation of the First City Physician and that it was dependent on the municipality for financial support from 1909. Babies who attended the milk depots were examined once a fortnight by a doctor who, if need be, also provided medical treatment. Nurses visited the infants in their homes, ensuring that mothers complied with the instructions given by the doctors. However, the main aims of the milk depots were, firstly, to provide sterilized milk for infants who could not be raised solely on breast milk and to instruct their mothers in "rational" infant care. Secondly, by providing economic assistance in the form of milk and cash, the society enabled poor working mothers to stay at home for a month or two after the childbirth and to breast-feed their infants. Without this assistance, which at best was equivalent to one month's wage, these mothers would have had to resume factory work immediately after childbirth. It seems that the society initially started providing economic assistance for breast-feeding mothers in order to silence the critics who argued that the milk depots promoted artificial feeding. However, from 1908 the importance attached to this service clearly increased, even though the number of mothers who were assisted remained relatively small. In 1924, the society provided assistance in the form of cash and milk for 127 mothers who comprised only 3 per cent of all women who gave birth in that year.\textsuperscript{145}

Unlike the Birmingham infant welfare centres, which sought to keep all working-class infants under supervision, the milk depots in Gothenburg concentrated on babies who were wholly or partially bottle-fed, and therefore susceptible to epidemic diarrhoea. The leading members of Föreningen Mjölkdroppen were confident that by offering financial inducements - free sterilized milk, medical care and economic assistance - the milk depots would succeed in attracting a large proportion of the mothers who experienced difficulties in breast-feeding. In 1911, sterilized milk was supplied for 13 per cent of all infants born in Gothenburg, and in 1924 for 9 per cent. At the same time in Birmingham, the proportion of infants who attended infant welfare centres was about 75 per cent. The Gothenburg authorities were generally happy with the results of the milk depots. In the years 1904-08 the overall rate for infant mortality for Gothenburg was 98 per thousand live births, while the rate for artificially fed babies who attended the milk depots was 91. In 1911 the overall rate for the city was 77 and the rate for the depot babies was only 33.\textsuperscript{146}

**Women as mothers and workers**

In 1913, the City Council established a Child Welfare Office, which was answerable to the Public Health Committee, to protect the interests of illegitimate children and to promote their health and well-being. The main functions of the Office were, firstly, to help unmarried mothers gain legal recognition of the paternity

\textsuperscript{145} GSH 1909:252, 3-5, 25-6 and minutes 7. 1. 1910 item 6; 1910:59; 1911:27 and minutes 16. 2. 1911; 1911:264 and minutes 30. 11. 1911 item 17; 1911:118A, 11-3; 1918:93; 1919:73 and minutes 27. 2. 1919 item 28; 1919:174A, 120-2; 1924:110 and minutes 27. 3. 1924 item 24; 1925:145, 2-3; Höjer, 'Mjölkdroppar', 44-9; Sundell, 'Effektivare spädhalsvård', 239-49. See also Weiner, 'De "olydiga" mödrarna', 488-50. The municipal funding accounted usually for 30-50 per cent of the Society's income.

\textsuperscript{146} GSH 1911:27, 5; 1912:120A, 7; 1925:145, 2-3.
and economic assistance from the fathers, and secondly, if the mother wanted to give her child away, to assist her in finding a good foster home. Thirdly, the Child Welfare Office was to supervise foster homes to ensure that children were not abused or neglected. However, the experts and executives involved in the running of the Child Welfare Office soon realized the limits of their power to alleviate the problems. In 1916, 80 unmarried mothers who were looking for a foster home turned to them for help. In 30 cases, the Office took no action, since the mother was unable to pay enough for the care of her child and therefore finding a reasonable foster home would have been impossible. Eventually, the Office managed to arrange for only 18 children to be placed in foster homes. Furthermore, the number of mothers who were helped to get economic assistance from the father was low, between 30-40 annually.147 The municipal authorities, who were clearly frustrated with their inability to deal with these questions, called for new legislation which would have conferred new powers on them to 'protect' unmarried mothers and their children.

The 1917 Illegitimate Children Act (Lagen om barn utom äktenskap) was the answer to some of their problems. The act, which went some way towards improving the legal position of unmarried mothers and their children, enabled municipal authorities to put pressure on the father not only to pay child support but also to maintain the mother for six weeks before and after the childbirth. However, if the new legislation improved the economic situation of unmarried mothers and their children, it also subjected them to demeaning supervision. An unmarried woman who was expecting a child had to notify the Child Care Committee of her pregnancy three months before the confinement. After receiving the notification, the Committee appointed a 'guardian' to advise and supervise the mother, to ensure that fatherhood was established and to protect the interests of the child.148

The authorities admitted that much still remained to be done. Payments from fathers tended to be low and were often not paid, which meant that even in the 1920s and 1930s a large proportion of unmarried mothers and their children experienced great poverty.149 Self-sufficiency was simply not achievable by many of these families, since women's earnings were often below the subsistence level. However, intervening in the labour market was outside the accepted sphere of municipal activity and therefore the Gothenburg health authorities did not even contemplate dealing with the women's limited leverage in the workplace. What the authorities did in order to help married and unmarried mothers maintain their families was to provide economic assistance for voluntary nurseries. These institutions were praised for providing mothers "with

147 GSH 1912:18; 1912:273 and minutes 31. 10. 1912 item 8; 1919:156, in particular 9-11.

148 GSH 1919:156; 'Tillämpningen av barnafaderns bidragsskyldighet gentemot modern enligt lagen om barn utom äktenskap', in SOU 1929:28, 100-4. See also, Elgán, 'Le législateur au secours de la mère célibataire'; Ohrlander, I barnens och nationens intresse, 148-52.

149 A survey which was conducted in 1926 in Malmö showed that only 65 per cent of the fathers who had been ordered to support the mother actually provided assistance. See 'Tillämpningen av barnafaderns bidragsskyldighet', in SOU 1929:28.

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opportunity to earn money and supplement the family income." Unsurprisingly, the Gothenburg City Council and the Public Health Committee did not condemn working mothers. Nor were they active in discussing possible harmful effects which mothers' employment could have had on their children's health. At the national level the question inspired more interest. After repeated calls for legislation to protect women and the next generation, four week's compulsory maternity leave had been introduced in 1900 and extended to six weeks in 1912. The law proved as ineffectual as its British counterpart. Acutely aware of the economic hardship which unpaid maternity leave would cause some families, doctors often considered work the lesser evil and signed a certificate, stating that a mother's health was not in danger. Economic assistance provided by milk depots enabled some working mothers to stay at home for a month or two, but services of this type were small in scale. A maternity insurance scheme was not introduced in Sweden until 1931.

**Problem mothers**

Educating working-class women to a more mature understanding of their duties as mothers was a cause with which many City Councillors in Gothenburg heartily sympathized, but it needed a serious crisis such as the food shortage in 1917 to actually put the question on the agenda. In discussing the problems caused by the food shortage, the City Councillors agreed on the seriousness of the situation. Some Councillors predicted a breakdown of law and order, the others expressed their concern, for example, over the effects which the food shortage had on women's and children's health. The Councillors pointed out that in many families the mother and the youngest children were malnourished, since the available budget for food was spent mainly on the husband and on older children who worked outside the home. Central and local government agencies and voluntary associations had already appropriated funds to alleviate the problem, but the City Councillors were of one mind about the need for further measures. The proposal that working-class women should be advised as to how to manage their household and how to prepare cheap and nutritious food attracted more support than any other proposal.

Three domestic science teachers were appointed as municipal household advisors (hem konsulent) in August 1917. While one of them organized classes in cookery and household management, the others visited 'problem homes'. During the second half of the year 1917, they visited 54 homes and spent on average four days in each, instructing mothers in cooking and other household chores. The advisors were also allowed to

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150 GHS 1909:252 (the quote is from page 11) and minutes 7. 1. 1910 item 6; 1926:192 and minutes 12. 5. 1926 item 24.

151 SOU 1929:28, 21-31; Isberg, 'Barnavård', 68. See also Ohlander, 'The invisible child?', 60-7.

152 GSH 1917:97 and the discussion 19. 4. 1917 item 7.


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provide economic assistance for the poorest families. Indeed, in many cases, the advisor had to buy some household utensils and basic foodstuffs for the family before she could start instructing the mother. A few weeks later, the advisor visited the family again in order to check whether her teachings were put into practice. This service, which had been introduced as an emergency measure, turned out to be very popular, and the municipality continued to provide it until 1923, when it was taken over by a voluntary association.154

In 1917, the City Council set up a working party to look at the problem of infant mortality. In their report, the working party pointed out that mothers' ignorance of the safe methods of infant care rather than poverty was the largest obstacle to improving the health and well-being of infants. Consequently, they recommended that the Health Committee appoint a childcare advisor (barnvårdskonsulent) to ensure that also the poorest mothers would have an opportunity to learn about mothering from an authoritative source. The Health Committee supported the proposal, and the City Council accepted it.155 The child care advisor visited, usually at the request of a medical practitioner, a midwife or a foster child inspector, homes where mothers experienced difficulties in childcare. Like the household advisors, she visited only a small number of 'problem families', 100-200 annually. If the child care advisor thought that more than advice was needed to help the family, she could send for a municipal district nurse or a home help or she could contact the poor law authorities, an orphanage, a nursery or a milk depot.156

In 1923, a governmental committee which had been asked to consider different plans to improve infant welfare, emphasized the importance of preventive medicine and health education. The Committee recommended that Swedish health authorities should follow the example set by the British authorities and establish infant welfare centres.157 At the same time in Gothenburg, milk depots were increasingly criticized for being an outmoded and inefficient way of tackling the problem of infant mortality. The consultant paediatrician of the children's hospital, Dr. Arvid Wallgren, launched a campaign, the main aim of which was to turn the old milk depots into 'modern' infant welfare centres.158 As the public health officials in Birmingham, Wallgren attributed the high rates of infant mortality largely to mothers' ignorance. Instead of providing sterilized milk, the new infant welfare centres encouraged breast-feeding. Furthermore, instead of concentrating on the small number of problem families, the purpose of the new infant welfare centres was

154 GSH 1919:546 and minutes 22. 12. 1919 item 14; 1921:260; 1921:484 and minutes 22. 12 1921 item 15; 1923:34.

155 GSH 1917:295; 1918:79 and minutes 28. 2. 1918 item 33; 1918:169 and minutes 8. 5. 1918 item 17; GSA, HVN I, minutes 3. 4. 1918 item 71.

156 GSA, HVN I, minutes 20. 3. 1918 item 66; 3. 4. 1918; GSH 1918:79, 1918:169 and minutes 8. 5. 1918 item 17; 5. 6. 1918 item 108; 3. 7. 1918 item 127; Årsberättelser för 1918-1928. In 1928, the Child Care Committee took over this service.

157 Sundell, 'Effectivare spädbarnsvård'. See also, Urban Hjärne, 'Några drag ur engelak barnavårdsverksamhet', Nordisk Medicinsk Tidskrift 2 (1930), 204-7.

158 GSH1926:58, in particular 8-9; Wallgren, 'Barnavårdscentraler'; Sundell, 'Effectivare spädbarnsvård'.

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to monitor the development of all children. While in 1926 medical doctors who worked for the milk depots examined only 11 per cent of all children born in Gothenburg, in 1935 the percentage of children who attended infant welfare centres was 54.159

--- CONCLUSION ---

The ways in which the problem of infant mortality was understood and defined in Britain and Sweden became more uniform during the period examined here. The Birmingham and Gothenburg infant welfare campaigns, which had been radically different in the early years of the twentieth century, clearly converged in the 1920s and 1930s. The Birmingham authorities increasingly ignored the protests of the independent medical practitioners and introduced municipal medical services, and the Gothenburg authorities established infant welfare centres which concentrated exclusively on examining babies and on instructing their mothers in infant care. However, there were still great differences in emphasis. The Assistant MOH for Birmingham, Dr. Ethel Cassie, analyzed these differences, upon returning from her tour in Northern Europe in 1930. She argued that the Birmingham infant welfare centres were vastly superior to equivalent institutions abroad: In other Northern European countries "the child welfare work (in the public health sense) is definitely behind our standard." What compensated for the deficiencies in educational services in the Nordic Countries and the Netherlands was the cleanliness of cities and good medical and midwifery services. In Swedish, Dutch and Danish cities, Cassie claimed, the standard of hygiene was high, "there (was) little desperate poverty, the midwifery (was) of a high standard.. and there (was) a large provision of hospital beds for children."160

It is hardly surprising if the Birmingham infant welfare centres indeed were superior to the equivalent institutions in Gothenburg or in Sweden in general. From the early years of the twentieth century, the Birmingham health authorities had defined maternal ignorance as the major cause of infant death and had concentrated on helping working-class mothers achieve 'acceptable' standards of child-care and housewifery. This campaign, the centrepiece of which was the lifestyle theory of disease, ran smoothly in upper working-class and lower middle-class areas, where mothers had time and means to put the teachings they received into practice. The campaign not only safeguarded the health of these mothers and their children, but at best it could also boost the work they performed, provide them with an opportunity to demonstrate their 'respectability', and give them a sense of well-being. On the other hand, the campaign which emphasized personal control over disease could not recognize, let alone deal with, many problems confronting the poorest

159 Föreningen Mjölldroppens barnavårdcentraler i Göteborg, Årsberättelser för 1930; 1935.

mothers. On the contrary, it often added to the hardships which many poor mothers already suffered, and therefore it could even increase the disparity of health and well-being between different social groups.

The Birmingham infant welfare campaign buttressed the family model in which husband and wife had strictly complementary roles to play, and mothers who transgressed the maternal norm, for example, by working outside the home were denounced in no uncertain terms. The health authorities argued, both implicitly and explicitly, that proper infant care could only be provided by a child’s natural mother, and all children who were cared for by anyone other than the mother were, almost by definition, ‘neglected’. Promoting women’s exclusive mothering and domesticity was possible in Birmingham, since the vast majority of working-class men were able - or were considered to be able - to maintain their families. Hence in constructing infant welfare policies the health authorities managed to reconcile two important ideals: the male-bread winner family model and the family’s responsibility for self-support. Furthermore, the Birmingham health authorities were careful not to damage the interests of the independent medical practitioners. Until the late 1910s they clung to the view that the well-being of infants could be secured without publicly funded medical care, and even in the 1920s and 1930s the municipal provision was very limited.

In many aspects, the Gothenburg campaign offers a dramatic counterpoint to the Birmingham one. In Gothenburg, questions concerning infant health and welfare were often defined as technical matters which were to be resolved by medical doctors, lawyers, nurses and child care advisors. These experts were fully aware that the definitions of this type would vastly extend professional opportunities in medicine, nursing and social work. The Gothenburg campaign, in which experts played the key role, provided sterilized milk for infants who could not be raised solely on breast milk, medical care for children who were ill, nurseries for children whose mothers worked outside the home and legal advice for mothers who sought to gain economic assistance from the father. At best the Gothenburg campaign helped mothers to cope with their immediate problems. However, a large proportion of the mothers who used these services were defined as ‘problem mothers’ and were subjected to close supervision and the dismissal of privacy. The technical approach chosen by the Gothenburg authorities often lost sight of mothers and infants as individuals who had a family and a home.

The Gothenburg authorities, as their counterparts in Birmingham, sought to ensure that children were brought up in stable families. However, the Gothenburg and Birmingham authorities clearly had different views on what a ‘stable’ family consisted of and what its members should properly do. The Gothenburg health authorities recognized that, in many cases, it was impossible to place the responsibility for supporting an entire family exclusively on the father. Many unskilled male workers in Gothenburg did not earn enough to support their families. Furthermore, the number of unmarried mothers who maintained their children entirely by themselves was high. Hence instead of emphasizing the complementary roles of mothers and fathers, the health authorities discussed possible ways of securing more parental responsibility. They stressed that both fathers and mothers were responsible for maintaining their children and that parents who evaded this responsibility were largely to blame for the high infant death rates. Moreover, the Gothenburg
authorities took the view that in some cases a child's natural mother and father could not provide the best care.

Although the approaches which were chosen in Gothenburg and Birmingham were different, the infant mortality rate was steadily declining in both places (see Figure 4.5.). The Birmingham and Gothenburg Health Committees rushed to interpret the favourable development as a validation of their campaign. However, with the benefit of hindsight, many researchers have suggested that early twentieth-century health authorities may have been too eager to congratulate themselves. British writes such as Carol Dyhouse and Robert Woods et al, who have discussed different reasons behind the infant mortality decline, have pointed out that death rates were not declining only in the towns which launched energetic infant welfare campaigns but also in towns which were slow to provide these services.161

**Figure 4.5. Infant mortality per 1,000 live births in Birmingham and Gothenburg, 1901-36**

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161 Dyhouse, 'Working-class mothers'; Woods, Watterson and Woodward, 'The causes of rapid infant mortality decline, Part I and II'.

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In the early twentieth century, tuberculosis impinged on public consciousness to a far greater extent than ever before. The disease, which had been a major cause of death and chronic illness throughout the nineteenth century, eventually assumed the dimensions of a public, political problem. Public health authorities in both Britain and Sweden attributed the awakening of their interest mainly to new accurate knowledge about the disease. For decades they had "recognized" tuberculosis as a contagious disease, but disagreement over the finer details about its transmission and behaviour had "prevented action being taken in the past." Robert Koch's identification of the tubercle bacillus in 1882 and subsequent experiments by him and other researchers had finally put an end to these deep-seated conflicts. As a result, health authorities 'knew' that, in the majority of cases, the tubercle bacillus was transmitted from person to person by droplet infection and that it depended on infected persons' state of resistance whether they developed disease or not. These new indisputable facts, it was argued, equipped public health authorities to deal with the problem by prescribing the direction and form which an effective anti-tuberculosis campaign was to take. Speculations about the role of heredity or wider environmental factors in causing tuberculosis could cease and efforts be concentrated on the essentials: controlling the spread of the bacillus and building people's resistance to infection.

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2 In this chapter, and in the thesis in general, the term 'tuberculosis' is used as a synonym for pulmonary tuberculosis. When the scope of discussion is widened to include the non-pulmonary forms of tuberculosis, this is expressly stated. In British public health literature pulmonary tuberculosis was called 'phthisis' or 'consumption' until the early 1920s, but 'tuberculosis' and 'pulmonary tuberculosis' were increasingly used after that. In early twentieth-century Sweden, pulmonary tuberculosis was commonly known as lungsot or lungtuberkulos.

3 Special Report by the Medical Officer of Health on Further Measures for the Prevention of Consumption in the City of Birmingham (hereafter *Report by the MOH on Consumption*) (Health Department, Birmingham 1906), 8.

4 For Gothenburg and Sweden, see Göteborgs Stadsfullmäktiges Handlingar (hereafter *GSH*) 1903:141; Betänkande och förslag af den uaf Kungl. Maj: i den 20 oktober tillsatta kommitté för verkställande af utredning...
Another reason for launching the campaign in the early twentieth century, health authorities claimed, was the severity of the problem: the high death rates from tuberculosis and the pre-eminence of the disease among major killers. In his annual report for the year 1900, Karl Gezelius, the newly-appointed First City Physician for Gothenburg, drew policy-makers' attention to the large percentage of deaths caused by different forms of tuberculosis. Pulmonary tuberculosis claimed no less than 19 per cent and other forms of the disease 7 per cent of all who died during that year in Gothenburg. Much cause for concern was also given by comparative studies which showed that Gothenburg's death rate from tuberculosis (almost 3.0 per thousand population) was, firstly, near the top in tuberculosis mortality in Sweden and, secondly, compared unfavourably with that of many German and British towns. In Birmingham, the percentage of deaths caused by this disease, albeit much lower than in Gothenburg, was also considered unacceptably high. In 1901, pulmonary tuberculosis accounted for 9 per cent of all deaths and other forms of the disease for 3 per cent.

As a major cause of death, tubercular diseases were exceeded by another group of diseases: bronchitis, pneumonia and pleurisy. Yet in the public health debate, tuberculosis assumed a far greater importance than these leading destroyers of life. While bronchitis usually killed elderly people and infants, pulmonary tuberculosis was a disease which "uniformly attacks young adults ... on whose education and training much money has been spent." Birmingham's death rate from pulmonary tuberculosis (about 1.4 per thousand population) bore rather favourable comparison with the death-rates for many other large cities in Europe, but it was clearly higher than the average for England and Wales.

5 Goteborgs halsovardsnamsnds arsberattelse (hereafter Arsberattelse) for 1900, 43-4; GSH 1900:104, 1, 5-6; 1902:90.


7 Annual Report for 1900, 6-8; for 1901, 46-7.

8 Report by the MOH on Consumption, 2.

9 Annual Report for 1912, 38; Report by the MOH on Consumption, 4 and Chart No. 1; Linda Blyder, Below the Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain (Oxford 1988), 7, 10; Kearns, 'Zivilis or Hygaea', 102.
The account which the health authorities themselves gave of the early stages of the anti-tuberculosis campaigns has been challenged by many writers. They have shown that high tuberculosis mortality and Koch's work were neither the only nor the most important motivating forces behind the early twentieth-century anti-tuberculosis movement. In particular, the timing of the campaigns clearly points to reasons beyond bacteriology or the level of mortality.\textsuperscript{10} Although the death rates from tuberculosis certainly made depressing reading in Birmingham and in particular in Gothenburg in the early twentieth century, both towns had experienced much higher rates in the preceding decades. Tuberculosis mortality had been declining in these towns in the late nineteenth century and there was no sudden increase in the incidence of the disease at the turn of the century which would have provoked public criticism and prompted health authorities to consider a fresh approach to the problem (See, Figure 5.1). Moreover, health authorities were fully aware of

\textit{Figure 5.1. Tuberculosis* mortality per 1,000 population in Gothenburg and Birmingham, 1875-1905}

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\end{center}

* The figure shows the death-rate for Birmingham registration districts (Birmingham, King’s Norton and Aston), not for the City of Birmingham. See, Special Report by the MOH on Further Measures for the Prevention of Consumption in the City of Birmingham (Health Department, Birmingham 1906), 4-5.

Sources: Annual Reports of the Registrar General of Births, Deaths and Marriages in England and Wales, 1875-1901; Ernst Almquist, 'Dödorsakerna i Göteborg 1861-85', in Göteborgs helsövårdsmändns årsberättelse för 1888, 90-1; Göteborgs helsövårdsmändns årsberättelser för 1885-1901; Statistisk årsbok för Göteborg för 1939, 9-10.

\textsuperscript{10} See, for example, Bryder, Magic Mountain, 2, 15-22; Barnes, Social Disease, 13-20.
The Medical Officer of Health (MOH) for Birmingham, Dr. John Robertson, claimed that the chart showing the decline in tuberculosis mortality in the late nineteenth century was "one of the most satisfactory that can be produced as showing a real improvement in the public health." He was also convinced that tuberculosis mortality would continue to decline irrespective of whether special measures were taken or not. Similarly, a governmental Tuberculosis Committee which considered different approaches to the problem in Sweden in the early years of the twentieth century determinedly dismissed the popular assumption that the disease was becoming increasingly prevalent. Seeking to create an impression of unbroken progress in the fight against ill-health, the Committee reminded the readers that death rates from tuberculosis had been considerably higher in the past. Indeed in the early nineteenth century, Stockholm with a tuberculosis death rate of 9 per thousand population had been a strong candidate for the title TB capital of Europe, and Gothenburg's death rate had hovered between 4 and 5. In the 1870s, tuberculosis still caused a death rate of 3.5 per thousand population in Gothenburg.

It is likely that tuberculosis mortality began to figure more strongly among contemporary concerns, as many epidemic killers such as typhus and cholera disappeared as significant causes of death in the course of the nineteenth century. Yet in absolute terms, death rates from tuberculosis in early twentieth-century Birmingham and Gothenburg were well below the levels which prevailed in the preceding century.

As for the effect of Koch's work, the considerable time lag between his discovery and its practical application suggests that the anti-tuberculosis campaign owed much less to this scientific breakthrough than the authorities claimed. Linda Bryder, David S. Barnes and Georgina D. Feldberg have shown that most British, French and American medical doctors were slow to respond to Koch's work and to consider its practical value. Similarly, in Sweden, his invention provoked heated academic discussions in medical associations but had little impact on the public health policy of the 1880s and early 1890s. At the local level, in both Gothenburg and Birmingham, almost 20 years lapsed between the discovery of the tubercle bacillus and the

11 Comparing tuberculosis death rates across national borders or over time in a single country is extremely problematic, since the understanding of the disease, the methods of record-keeping and incentives to conceal the occurrence of a tuberculosis death in the family varied from society to society and changed from one period to another. Anne Hardy, "Death is the cure of all diseases": using the General Register Office Cause of Death Statistics for 1837-1920, Social History of Medicine 7 (1994), 473-92; Linda Bryder, 'Not always one and the same thing:' the registration of tuberculosis deaths in Britain, 1900-1950, Social History of Medicine 9 (1996), 253-65; Allan Mitchell, 'An inexact science: the statistics of tuberculosis in late nineteenth-century France', Social History of Medicine 3 (1990), 387-403; David S. Barnes, 'The rise and fall of tuberculosis in Belle-Epoque France: a reply to Allan Mitchell', Social History of Medicine 5 (1992), 279-90.

12 Report by the MOH on Consumption, 4.

13 Dovertie, 'Öfversikt', 3; Johansson and Moosberg, Lungsotsdödligheten, 24-6.

14 Carl Runborg and Gustav Sundbärg, 'Dödligheten af lungtuberkulos i Sveriges städer, åren 1861/1900', Statistisk Tidskrift (1905), 198-224; Gustav Sundbärg, 'Dödligheten af lungtuberkulos i Sverige åren 1751/1830', Statistisk Tidskrift (1905), 178-85; Puranen, Tuberkulos, 164-7, 172-80, 245-7. See also, footnote 11.

launching of the anti-tuberculosis campaign. A major reason why health authorities began to transform this scientific idea into practical policy at the turn of the century was, as in the case of the infant welfare movement, the growing concern over national inefficiency. In a climate of intensifying international rivalry, decision-makers in major western European powers such as Britain and in more peripheral countries such as Sweden came to consider tuberculosis as a serious threat to the future of their nation. A concerted campaign to deal with tuberculosis, primarily a disease of young adults, was seen as an integral part of the nation's efforts to uphold its interests in the international arena. However, equally important, albeit less publicized, was the role which the anti-tuberculosis campaign played in the management of social problems and in mediating urban conflicts at home. In the late nineteenth century, the techniques of analysis and intervention which bacteriology provided came to be seen as an efficient and value-free way of dealing with urban problems and thus indispensable to the governance of large industrial cities.

Scientific knowledge and techniques were an important part of the anti-tuberculosis campaigns but they did not determine the form or direction the campaigns took. Owing to close international links between medical doctors working in the field and to specialized journals and conferences through which new research findings were shared, there were many universal features in Swedish, British, German and French anti-tuberculosis movements. Yet all these campaigns had also national characteristics which distinguished them from each other, and which sharply reveal the important part which political and social concerns played in determining the form of anti-tuberculosis schemes. The new 'truth' about tuberculosis clearly allowed different definitions of the disease and left ample room for disagreement on what measures would be the most appropriate to deal with the problem. In this chapter, the Birmingham and Gothenburg anti-tuberculosis campaigns are compared and their differences and similarities are analysed to show how the definitions of the problem and responses to it were bound to the relationships of power and structures of inequality in these cities.

The comparison between Gothenburg and Birmingham reveals sharply health authorities' tendency to take those aspects of the new 'truth' for granted that supported their preconceptions about the problem and to selectively ignore research findings that challenged their understanding. Some public health experts and executives concentrated their attention almost exclusively on the tubercle bacillus, seeking to create an impression of tuberculosis as a medical problem, devoid of deep societal roots. For them, the campaign against tuberculosis was basically a scientific battle against the bacillus led by experts on medicine and

16 GSH 1900:104; Annual Report for 1898, 28-31; for 1901, 26-8.

17 See, for example, David Armstrong, Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century (Cambridge 1983), 7-18, Gerry Kearns, 'Tuberculosis and the medicalisation of British Society, 1880-1920', in John Woodward and Robert Jütte (eds), Coping with Sickness: Historical Aspects of Health Care in a European Perspective (Sheffield 1995); Barnes, Social Disease; Feldberg, Disease and Class; Bryder, Magic Mountain.

18 For German anti-tuberculosis movement, see Paul Weindling, Health, Race and German Politics between National Unification and Nazism, 1870-1945 (Cambridge 1989).
public health. Others emphasized the importance of the research findings which indicated that about 90 per
cent of the urban population in Europe had at some time suffered tubercular infection and that only a small
percentage of them actually developed full-blown tuberculosis. These experts argued that the theories which
concentrated on the bacillus did not come close to explaining tuberculosis, since the disease was born and
bred of unhealthy habits which weakened the body's own defence mechanism. The only effective way of
combating the disease was health education. Yet others, albeit only a few, focused on social and
environmental factors such as poverty and defective housing which were believed to make people susceptible
to diseases, and called for changes in the economic order. The Birmingham and Gothenburg tuberculosis
schemes, as most anti-tuberculosis campaigns in Western countries, combined these approaches, fighting the
bacterial, behavioural and environmental causes of tuberculosis at the same time. In reports which the public
health authorities published, all of these approaches could easily coexist, and even come and go in the course
of the text. Yet health authorities had a tendency to give weight to one line of reasoning and to play down
the others depending on policy legacies and on wider political and social aims behind the health policy. All
these approaches, albeit based on 'value-free' research findings, furthered some social and political aims.

The preceding chapter (4) discussed how 'scientific' infant welfare campaigns served to regulate urban family
life. The policies which public health authorities in Birmingham and Gothenburg pursued to improve the
welfare of infants reinforced, firstly, the existing 'gender contract', the explicit and implicit rules which
deﬁned the relationship between sexes in society and, secondly, the ideal of the family's responsibility for
self-support. In contrast to infant mortality which was related to dysfunctional families, tuberculosis was
viewed as a more public problem and was associated with a wider range of social contacts and with public
space as well as homes. This chapter examines, firstly, the way in which the question of defective housing
was integrated into the official understanding of tuberculosis in Birmingham and Gothenburg. The debates
about housing and tuberculosis reveal sharply the contrary demands which were imposed upon public health
authorities by the operation of their conﬂicting roles. Health authorities were not only combating
tuberculosis but they also sought to maintain social order and to regulate the local economy. In both
Birmingham and Gothenburg authorities used scientiﬁc knowledge about tuberculosis, albeit in different
ways, to legitimate municipal intervention in homes and both intervention and non-intervention in the
housing market.

Secondly, this chapter examines how anti-tuberculosis campaigns re-organized and regulated urban society.
Tuberculosis was one of the 'social diseases' which were constituted not only in the individual body but also
in the social body. Hence in order to control tuberculosis health authorities sought to regulate the relations
between the sick and the healthy by different strategies which ranged from health education to the segregation
of the sick. The chapter discusses the question of how the balance between individual rights and collective
interests was weighed in Birmingham and Gothenburg and, more importantly, how the strategies which
aimed at shaping the relations between the sick and the healthy served to regulate and mediate the relations
between, for example, different social classes. The values, attitudes and habits which anti-tuberculosis
campaigns promoted as healthy and rational were usually broadly in line with the way of life of the middle
class. Furthermore, anti-tuberculosis campaigns had an impact on the relationship between urban space and social classes, furthering either social segregation or integration in society. The last section of this chapter looks at how the anti-tuberculosis campaigns served to shape the relationship between society and children and how the lack of power which children experience in age relationships manifested itself in the campaigns.

Thirdly, the chapter discusses the extent to which anti-tuberculosis campaigns were products and prisoners of the interests of the medical profession. This theme was already examined in the preceding chapter which showed that the structure of the health care system - and in particular the relative importance of public and private sectors - had a marked impact on the direction which the infant welfare campaign took. Tuberculosis, however, was a 'second-class disease', which never was of great interest to the British general practitioners and voluntary hospitals. In consequence in Birmingham, as in Gothenburg, public health authorities took most of the responsibility for dealing with the problem. In both towns, health officials working in this field staked greater territorial claims by drawing policy-makers' attention to new problems which were linked or could be linked to tuberculosis. The question explored in this chapter is whether the Gothenburg health officials who held a relatively strong position within the medical profession and the Birmingham officials who did not enjoy the same status were inclined to define the problem of tuberculosis differently. Can the different policies be explained in terms of the professional manipulation of power and status?

HOUSING, HOMES AND HABITS
TWO DEFINITIONS OF TUBERCULOSIS

GOTHENBURG

What public health authorities saw when they examined the problem of tuberculosis depended very much on what they expected or wanted to see. The Gothenburg health authorities clearly wanted to concentrate their attention on unhygienic flats, attics and cellar dwellings. They viewed tuberculosis, first and foremost, as a "dwelling-disease" (bostadssjukdom) which chose most of its victims from overcrowded, ill-ventilated, dark and filthy homes. This view of tuberculosis was shared by many key figures in the national anti-tuberculosis campaign. Dr. Ernst Almquist, the Professor of Hygiene in Stockholm, emphasized in his textbooks that poor housing conditions rather than poverty per se laid behind the prevalence of tuberculosis in large Swedish towns.

19 GSH 1900:104; 1902:2; 1908:252; Årberättelse för 1902, 40; för 1911, 10-3; för 1912, 10-3; Gösta Gothlin, 'Några bostadhysgieniska reformkrav', in Göteborgs Lakaresällskaps förhandlingar, Hygiea 79 (1917), 1152-6.

20 Ernst Almquist, Allmän hälsovårdslära med särskilt anseende på svenska förhållanden för läkare, medicine studerande, hälsovårdsmyndigheter, tekniker m. fl. (Stockholm 1897), 740-3; Ernst Almquist, Hälsovårdslärens framsteg under senaste åren (Stockholm 1902), 26-9. See also, for example, G. H. von Koch, 'Bostadsfrågan', in G.
1907-08, the "adverse" housing conditions played an important role in both explaining the prevalence of the disease and in determining the direction of the Committee's recommendations.21

Unhygienic homes

As proof of the link between defective housing and tuberculosis, health authorities cited investigations conducted in Sweden and abroad. In France, as in Sweden, housing problems were closely integrated into the medical and social understanding of tuberculosis, and the Chief Tuberculosis Officer for Gothenburg, Dr. Gösta Göthlin, often used French research to support his arguments.22 An abundance of evidence was also available from Germany, Britain and the United States which backed up the health authorities' conclusion that the worse the housing conditions the higher the death rate from tuberculosis. In particular, cause for concern was given by studies which showed that there was a clear correlation, firstly, between house-size and the incidence of tuberculosis and, secondly, between overcrowding measured by persons per room and tuberculosis.23 In Gothenburg, a large proportion of inhabitants lived in houses which were both small and overcrowded. In 1910, about 63 per cent of the housing stock in Gothenburg had only one room or one room and a kitchen, and 38 per cent of town-dwellers lived at a density of more than 2 persons per room. The situation stayed basically the same for the following ten years, but improved somewhat during the 1920s. In 1930, small houses and flats constituted 57 per cent of the housing stock and 25 per cent of the population lived in overcrowded accommodation.24

Public health experts and executives also sought to substantiate their thesis that housing played the dominant role in the aetiology of tuberculosis by information which they gathered during their study trips. As early as 1900, the First City Physician, Karl Gezelius, considered the housing-tuberculosis connection while visiting Glasgow. The main purpose of his trip, and that of 60 other European medical doctors, was to follow emergency measures which the Glasgow health authorities were taking against a bubonic plague epidemic.

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H. von Koch (ed.), Social Handbok (Stockholm 1908), 79; Kerstin Hesselgren, 'En lifsfråga för vårt folk', Social Tidskrift (1904), 67-72.

21 Betänkande och förslag I, 3-16 and II (Stockholm 1908), 47-9; Karl Petrén, 'Tuberkuloskommitténs betänkande', Social Tidskrift (1908), 110-6.

22 For references to French or Swedish studies, see GSH 1908:252; 1913:337; Årsberättelse för 1911, 10-13; för 1912, 10-13; Göthlin, 'Reformkrav', 1153-4. For the French discussion about the housing-tuberculosis connection, see Barnes, Social Disease, 112-37.


24 Statistisk årsbok för Göteborg 1925, 99, 103, 105; 1939, 103-7; Werner Göranson and Gustaf Rosander, 'Vad siffrorna säger om göteborgarens sätt att bo', in Katalog för Göteborgs stads bostadsutställning "Bo bättre" (Göteborg 1936), 25-41; Artur Attman, Göteborgs Stadsfullmäktige 1863-1962. I: Göteborg 1863-1913 (Göteborg 1963), 278-9. The figures presented here are different from those in Attman's book. Attman has looked only at the flats/houses with less than 5 rooms and the section of the population which lived in these houses. See also Chapter 2, pages 42-3.
However, during his stay in the town, Gezelius also seized the opportunity to acquaint himself with public health policy more generally. In the eyes of the Swedish health official, there were two self-evident explanations to the vast improvement in Glasgow’s death rate in the late nineteenth century: extensive municipal involvement - both ownership and intervention - in activities which had an important bearing on people’s general health and the growing emphasis on institutional health care. As for tuberculosis, Gezelius found Glasgow’s mortality surprisingly low - 2.3 per thousand population in the early 1890s compared with 3.2 in Gothenburg - and was determined to attribute it to the active municipal intervention in housing. Yet the level of overcrowding could not explain the difference in tuberculosis death rates between these towns, since overcrowding was extensive in both Glasgow and Gothenburg - and actually more extensive in Glasgow. Gezelius, totally convinced as he was that housing was instrumental in understanding the problem of tuberculosis, skated around the problem of overcrowding and ascribed Glasgow’s better record to some other qualities of houses and their surroundings. The relatively low tuberculosis death rate in Glasgow was, he argued, chiefly due to the local authorities’ effective campaign to prevent the use of cellar dwellings and to provide play areas for children, where they could get fresh air.

In considering the role of housing in tuberculosis, public health experts invoked ideas of ‘soil’ and ‘seed’. Defective housing was doubly to blame. Firstly, it was pointed out that poor housing conditions rendered the human soil receptive. Living in damp, mouldy, ill-ventilated and filthy houses gradually diminished the body’s capacity for fighting off the infection and thus paved the way for the active disease. This question failed, however, to attract wide-spread interest among Swedish public health experts, and the discussion was usually determinedly steered into the second aspect, the seed. The risk of infection and of continuous re-infection was considered to be high in insanitary, overcrowded houses. Not only were the tubercle bacilli transmitted easily from person to person when people lived huddled together in small rooms, bacilli were also believed to thrive in filth, darkness and stationery air. Insanitary houses, it was argued, were an ideal

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25 At the turn of the century Glasgow was well-known for its municipal socialism both in Britain and abroad. See, Hamish Fraser, ‘Municipal socialism and social policy’, in R. J. Morris and Richard Rodger (eds), The Victorian City: A Reader in British Urban History 1820-1914 (London 1993), 258-80.

26 It is not clear, whether Gezelius was able to compare the extent of overcrowding in Gothenburg and Glasgow, since statistical information about Gothenburg’s housing stock and the level of overcrowding was quite defective until 1905. However, he must have been aware that overcrowding was a serious problem in Glasgow. In 1910-11, the level of overcrowding was clearly higher in Glasgow than in Gothenburg. If the contemporary standard of more than 2 persons per room is used to signify overcrowded accommodation, 38 per cent of residents in Gothenburg lived in overcrowded houses in 1910. At the same time (in 1911) in Glasgow, 56 per cent of town-dwellers lived in overcrowded accommodation. Statistisk årsbok för Göteborg 1925, 99, 103, 105; Richard Rodger, ‘Crisis and confrontation in Scottish housing 1880-1914’, in Richard Rodger (ed.), Scottish Housing in the Twentieth Century (Leicester 1989), 28.


28 GSH 1908:252. See also, von Koch, ‘Bostadsfrågan’, 79, 82.
breeding ground for bacilli.\textsuperscript{29} To emphasize the seriousness of the matter the Tuberculosis Officer Gösta Göthlin pointed out in 1911 that this problem was not limited to the poorest of the poor. Once tuberculosis had taken hold of the wage-earner, even relatively well-to-do working-class families were likely to face a life of deprivation. In his statement to the City Council, Göthlin argued that tubercular patients ended up in the worst houses available as certainly as though "a natural law" had forced them there.\textsuperscript{30}

\textit{Justifying intervention in homes}

Whether poor housing conditions in fact weakened bodily resistance to infection or facilitated the proliferation and transmission of bacilli is not relevant here. It is the way in which health authorities used scientific evidence to support their definition of tuberculosis and to justify municipal intervention in homes that is of interest. Although health authorities made use of wide range of studies to integrate housing into the definition of the tuberculosis problem, they rarely made an effort to show how exactly different elements of defective housing affected the incidence of tuberculosis. They indicated that there was a strong link but left its precise nature unspecified. As the disease was known to be transmitted by droplet infection, it was often presented as a common-sense fact that overcrowded and small houses presented a danger. When authorities cited scientific evidence to support these arguments, the studies they drew upon showed only a correlation, but not whether there was a causal link between overcrowding and tuberculosis. It was obvious that health authorities wanted to concentrate on the problem of overcrowding and were determined not to discuss, for example, what was the relative importance of overcrowding compared with that of other poverty factors like malnutrition and overwork. Findings and observations - such as the comparison between two grossly overcrowded cities, Glasgow and Gothenburg - which suggested that there were other important contributory factors to the prevalence of tuberculosis, were interpreted in a way which backed up the health authorities' view.

The evidence which authorities used to substantiate their argument that filth, darkness or stale air contributed to the proliferation of bacilli was even more fragmentary and superficial. The Tuberculosis Officer, Gösta Göthlin, cited a number of French studies which showed that the lighting of a house greatly affected bacilli. In bright daylight the tubercle bacillus was estimated to die within three days, in dark and mouldy cellars it lived for weeks or even months.\textsuperscript{31} The way in which stale air affected the incidence of tuberculosis was never thoroughly discussed. The simple reasoning behind the argument about the unhealthiness of ill-ventilated rooms was that stale air was 'disgusting' and 'intolerable', and therefore unhealthy. Similarly,
Gothenburg authorities considered it self-evident that filth was an ideal breeding-ground for bacilli and did not make any effort to pin down how exactly filth worked in favour of the disease.32

Public health experts usually took the view that the lack of sun-light was largely due to structural defects of cellar dwellings and of flats which faced small backyards. Ill-ventilation, by contrast, was considered to be almost entirely down to the inhabitants. The Chief Tuberculosis Officer argued that only 10 per cent of ill-ventilated houses had structural defects which prevented effective ventilation and therefore in 90 per cent of cases ill-ventilation was due to ignorance and carelessness. The want of cleanliness was attributed partly to structural defects of houses and partly to carelessness of inhabitants. These two factors, structural defects and people's indifference and ignorance, were inextricably interwoven in the housing-tuberculosis debate: houses were cold or over-heated, draughty or ill-ventilated, and difficult to keep clean or occupied by people who did not take care of their homes. To further illustrate the level of indifference The Chief Tuberculosis Officer pointed out that in almost 50 per cent of tuberculous homes children were not properly looked after.33

Admittedly, it would have been difficult to specify which aspects of insanitary housing were the main contributory factors to the prevalence of tuberculosis and to estimate the relative importance of these factors. Small working-class houses posed a multitude of dangers - with few clear-cut distinctions between them - for the health of the inhabitants. Yet the analysis of the housing-tuberculosis connection was often left deliberately vague so that health authorities had more latitude in how they dealt with the problem of tuberculosis and other related issues. Firstly, by emphasizing the correlation between the house-size and tuberculosis, the health authorities were able to define all small dwellings as problems and to justify intervention in the every-day life of all townspeople living in them irrespective of whether they suffered from tuberculosis or not. Secondly, by connecting a number of ultimately separate phenomena - tuberculosis, filth, lack of sunlight, indifference, ignorance, mistreatment of children and even alcoholism - they created a generalized picture of the home of a tubercular patient. In doing so, they justified the principle that all aspects of tubercular patients' and their family members' every-day life could be subjected to close surveillance.

Health officials did not have any difficulty in convincing the Health Committee and the City Council that tuberculosis and small insanitary houses were a dangerous combination. Difficulties only began when the attention turned to the question of how to approach the problem. There were clear differences of opinion about the best way forward. One line of thinking, which was advocated, for example, by the First City Physician and in particular the Chief Tuberculosis Officer Gösta Göthlin, was that the problem could not be

32 Professor Ernst Almquist explained in his textbook that bacilli lived longer in filth, since sun light could not destroy them. See Almquist, Halsövdårlårens framsteg, 18, 25. For further discussion about the processes by which certain smells, behaviours - such as spitting - and filth came to be considered as unhealthy and insanitary, see Alain Corbin, Pesthauch und Blütenduft: Eine Geschichte des Geruchs (Frankfurt am Main 1988); Norbert Elias, The Civilizing Process: The History of Manners & State Formation and Civilization (Oxford 1994); Manuel Frey, Der reinliche Bürger: Entstehung und Verbreitung bürgerlicher Tugenden in Deutschland, 1760-1860 (Göttingen 1997).

33 GSH 1900:104; 1913:337; Årsberättelse för 1911, 8-13; för 1912, 9-13; för 1913, 13-7.
solved without more active municipal intervention and subsidy. The municipality should control the private
building and renting sectors and support co-operative enterprises but also build houses. Göthlin claimed that
the social hygienic study of housing, which was conducted in Gothenburg in 1911, had clearly revealed that
tenants were not solely to blame. The problem revolved around two cores: the conservatism of poor
townspeople and the conservatism of decision-makers. While the former were unwilling to abandon their old
unhygienic habits, the latter clung to the traditional ways of dealing with social problems.34

Göthlin worked his way on to the Housing Committee in 1911 in order to convey his views to the key
policy-makers and to push the case for municipal housing.35 However, he was realistic enough to know that
housing problem could not be solved overnight, and he suggested that the municipality should first consider
providing more spacious, healthier houses specifically for tubercular patients and their families.36 This
suggestion met with cool response. The negative attitude to proposals to assist tuberculous families or, for
example, large families with their housing problems stemmed from both eugenicist and political concerns.
Most policy-makers considered it inappropriate and politically unwise that the municipality would assist the
poorest, 'inefficient' section of the population, when at the same time many respectable healthy working-
class families were struggling with housing problems.37 A widely held opinion among the City
Councillors was that the problem should be solved - at least in the short term - by removing infectious
tubercular patients who lived in small insanitary houses to hospitals.

**Unhygienic deaths**

Some of the eagerness to institutionalize 'advanced' tubercular patients stemmed from changing attitudes to
death. Dying at home - and in particular dying of tuberculosis - was increasingly seen as inconvenient and
unhygienic. Initially, health authorities directed their attention mainly to houses where tubercular patients
had died and to furniture, bedding, clothes and personal belongings which the patients had used while being
ill. Everything was to be disinfected before they were used by other members of the family or before they
were left with a pawn-broker or sold.38 However, soon the focus of attention shifted from patients' personal
belongings to dying patients themselves. Advocates of institutional care argued, explicitly or implicitly, that
lingering death of a tubercular patient was 'unhygienic' and 'unmanageable' at home and that advanced
tubercular patients posed a considerable danger to the health of their family members and friends. They were

36 *GSH* 1913:337.
37 *GSH* 1918:517.
38 *GSH* 1900:104.
highly infectious and often incapable of taking any necessary precautions or looking after themselves. Hence they were completely dependent on their family members and friends who in turn often lacked both the discipline and resources to take care of patients properly and to protect themselves from infection.39

In the eyes of public health experts and executives, institutionalization successfully interwove the collective and individual good. While the healthy members of society were protected against the killer disease, seriously ill tubercular patients were provided with the treatment they needed during the last months of their life. Death in the hospital was increasingly associated with positive values and qualities. Not only was it humane and hygienic, it was also manageable and well managed. Medical doctors working for tuberculosis hospitals were the best people to determine how to treat serious complications which many dying tubercular patients had and to decide when it was no longer worthwhile to treat them.40 As Philippe Ariès has pointed out death in the hospital came to be seen as "a technical phenomenon obtained by a cessation of care, a cessation determined in a more or less avowed way by a decision of the doctor and the hospital team."41 Constant medical supervision, professional nursing care, a hygienic environment and ever-improving hospital technology guaranteed the best death possible. A major problem, argued the First City Physician, was that in 1908 only 46 per cent of all people who died of tuberculosis in Gothenburg were able to avail themselves of this 'opportunity'.42

A number of other arguments for institutional care were brought forward. The First City Physician, Karl Gezelius, justified his enthusiasm, for example, by stressing that accumulating more knowledge about the disease and about different forms of therapy was of paramount importance. An informed choice about how to approach the problem of tuberculosis, he argued, would be possible only if health authorities had more experience of institutional care. Curiously, when the first hospitals were opened, Gezelius showed no interest in the critical evaluation of the 'experiment'. Nor did he make any effort to weigh the benefits brought by hospitalization against possible benefits of alternative approaches such as welfare and housing reforms and sanitary improvements.43 The importance of institutional care - both sanatorium and hospital care - was also emphasized by the governmental Tuberculosis Committee in 1907-08. They argued that in large towns local authorities should provide about as many hospital beds for tubercular patients as there were deaths annually from the disease. According to the report, Gothenburg, where 447 people died of tuberculosis

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39 GSH 1902:90; 1903:122C nr 17.


41 Philippe Ariès, Western Attitudes Toward Death from the Middle Ages to the Present (London 1994 printing), 88-9.

42 GSH 1910:105.

43 GSH 1902:2.
in 1905, would have needed about 390 beds. The Committee recommended hospitalization chiefly on the grounds that medical doctors were in favour of this approach and that foreign examples seemed to show that the isolation of infectious tubercular patients would alleviate the problem. It is interesting that Britain was used as an example which illustrated the advantages of institutionalization. For example, it was argued that in England the death-rate from tuberculosis was low mainly because so many people - including many infectious tubercular patients - died in institutions. However, in the late nineteenth century, in Birmingham, only about 15 per cent of deaths took place in hospitals and other public institutions. At the same time, no less than 20-25 per cent of deaths in Gothenburg occurred in institutions. This example illustrates how 'flexibly' health authorities used foreign examples to legitimate policies which they were determined to pursue.

Providing treatment and hope

Public health authorities were soon able to report on good results of their anti-tuberculosis propaganda and in particular on changes in the public's awareness and behaviour. As early as 1900, the First City Physician for Gothenburg, Karl Gezelius, praised the public for adopting somewhat healthier attitudes to tuberculosis and for acting more rationally. For example, an increasing number of people contacted the Public Health Department on their own initiative, asking health officials to disinfect their houses after a member of the family had died of tuberculosis. However, the alarmist propaganda also brought some serious problems in its train. The anti-tuberculosis campaign raised people's fear, contributing to the oppression of the victims of the disease. In the eyes of authorities, the anxiety and oppression were misplaced and disproportionate to the problem. In his annual report for 1900, Karl Gezelius warned the public not to give way to irrational fear which "so easily finds expression in the inhumane treatment of the sick." However, his appeal for calmness failed to win over all townspeople. Anxieties surfaced, for example, when the City Council in

44 Betänkande och förslag I, 4-6.

45 Dovertie, 'Öfversikt', 101-2. The Swedish Tuberculosis Committee was not alone in arguing that the low tuberculosis mortality in England could be ascribed to the institutional segregation of tubercular patients. For example, Arthur Newsholme claimed that the segregation of infectious tubercular patients in workhouses, workhouse infirmaries and lunatic asylums had exerted a powerful influence on the prevention of tuberculosis in England in the late nineteenth century. Arthur Newsholme, 'An inquiry into the principal causes of the reduction in the death-rate from phthisis during the last forty years, with special reference to the segregation of phthisical patients in general institutions', *Journal of Hygiene* 6 (1906), 304-384.

46 Annual Report for 1899, 5.

47 *Statistisk årsbok för Göteborg 1900*, 46, 68-73.

48 *GSH 1900:104*, 5-6; see also, for example, 'Smittoförende kläder' in *Göteborgs Handels- och Sjöfartstidning* 14. 7. 1900 (A). Från allmänheten.

49 *Årsberättelse för 1900*, 44; see also Buhre, 'Tuberkulosens bekämpande', 328; Victor Berglund, 'Försäkring mot tuberkulos', *Social Tidskrift* (1908), 258-9.
1902 was considering a plan to establish a tuberculosis hospital in a densely populated residential area. People living near the proposed site fiercely resisted the plan and accused public health authorities of inconsistency. They pointed out that health authorities had at first written alarmist newspaper articles and attached posters to the walls of trams, archways and stairwells, urging people to be extremely vigilant and to pay more attention to cleanliness. After creating TB hysteria, the authorities themselves showed a total disregard for the safety of the public by planning to house highly infectious cases of tuberculosis in the heart of the city.\textsuperscript{50}

Public health authorities were fully aware that the aggressive anti-tuberculosis propaganda needed some modifications in order to ensure the public's co-operation. Although it was important to fight complacency, sometimes by shock tactics, the public had to be convinced that health authorities had the problem under control.\textsuperscript{51} As a result, health authorities gradually shifted the emphasis of the campaign towards the prospect of curing the disease. This was not difficult, at least initially. Medical doctors attending tubercular patients were eager to develop their speciality and to introduce new forms of therapy, such as surgical intervention. Furthermore, the results achieved in German sanatoria in the late nineteenth and early twentieth centuries seemed to be extremely promising. In Hamburg, it was argued, 57 per cent of sanatorium patients were able to work and support themselves six years after completing their treatment.\textsuperscript{52}

\textbf{BIRMINGHAM}

The Birmingham public health authorities, as their counterparts in Gothenburg, were convinced that housing conditions affected the incidence of tuberculosis. In 1901-02, the MOH Alfred Hill drew policy-makers' attention to wide variations in tuberculosis mortality between the run-down central quarters and suburban residential areas. In "the older, poorer and less sanitary" areas such as St. Mary's and St. Bartholomew's wards death rates from the disease were three times as high as those experienced in the 'healthiest' wards, Edgbaston and Balsall Heath.\textsuperscript{53} Hill's successor, John Robertson, also considered the question of insanitary housing and tuberculosis in a special report which he wrote on the unhealthy conditions of the slum districts in 1904. He argued that damp, filthy, ill-ventilated houses and the low standard of amenities such as water supply, drainage, privies and yards largely accounted for the high death rates from, for example,

\begin{itemize}
  \item \textsuperscript{50} GSH 1902:90, and in particular 6-8; see also 1900:138, 1. See also Chapter 6.
  \item \textsuperscript{51} GSH 1902:2.
  \item \textsuperscript{52} GSH 1903:141.
  \item \textsuperscript{53} Birmingham Public Record Office (BPRO), Health Committee (HC), minutes 11. 3. 1902 item 7319; \textit{Annual Report for 1901}, 20-2.
\end{itemize}
tuberculosis. However, the way in which Hill and Robertson examined the housing-tuberculosis connection was somewhat different from the approach chosen by the Gothenburg authorities.

Unhealthy areas

Firstly, in Birmingham, the more privacy the family had, the more hygienic and healthy their home environment was assumed to be. Sharing space and facilities with neighbours, so it was argued, inevitably brought about health problems. Not only were shared water taps and communal privies associated with insanitary conditions and with low resistance to diseases such as tuberculosis, but also shared yards or stair wells were as a rule considered to be unhygienic. Robertson attributed the problem to people's (natural) disinclination to take care of communal space or facilities: "what is everybody's duty is nobody's duty." By linking shared facilities and communal space with ill-health, he provided legitimation for the municipal housing and town planning policy, one aim of which was to promote working-class suburban migration. The MOH claimed that the health of the population could be vastly improved if the working classes "spread themselves over a much wider area" and lived in self-contained houses "with sufficient space around or near" them. Rather than arguing, the MOH took for granted that reinforcing middle-class ideals of privacy and seclusion in society would promote the health of the population. In Gothenburg, where not only the majority of working-class people but also many middle-class people lived in flats, communal space - yards, entrances and stair wells - and shared facilities were not necessarily regarded as unhealthy and unhygienic.

Secondly, in Birmingham, both tuberculosis and infant mortality were closely associated with a few problem wards, known as unhealthy areas, where a high proportion of people lived in old deteriorating back-to-back houses. In death-rate tables these municipal wards were consistently at the top, and in maps - in visual depictions of the problem - they were always shaded black. Light colours were reserved for 'healthy' middle-class suburbs, and between these two extremes were the 'grey' wards which were inhabited mainly by lower middle-class and 'respectable' working-class families who "do look after themselves." In Gothenburg, by

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54 Report of the MOH on the Unhealthy Conditions in the Floodgate Street Area and the Municipal Wards of St. Mary, St. Stephen and St. Bartholomew (Health Department, Birmingham 1904).


56 Report by the MOH on Consumption, 23; Annual Report for 1912, 6.

57 Hjalmar Wallqvist, Bostadsförhållanden för de mindre bemiddade i Göteborg (Stockholm 1891), 7-11. However, large tenements which were divided into numerous small flats and where the standard of facilities was low were considered to be unhealthy places to live. Moreover, some writers regarded housing policy pursued by the state and local authorities in England as a relevant model for Swedish housing policy. Elias Heyman, 'Bostadsfrågans betydelse ur sanitar synpunkt', Hygiea 52 (1890), 329-50; von Koch, 'Bostadsfrågan', 82-7.

58 Annual Report for 1898, 8-15, 34-9; for 1901, 6-8, 21-2; for 1910, 4; Report of the MOH on the Unhealthy Conditions, 5-14.
contrast, the problems were pinpointed on the map and in the community. Instead of defining unhealthy areas, the Gothenburg authorities paid their attention, for example, to low-rent houses which were scattered in the socially mixed city centre and in working-class areas.59

The interpretation of the problem of tuberculosis was, thus, closely bound up with the urban form or, more precisely, with the health officials' understanding of what their communities were like and what they should be like. In Birmingham, where the development of socially segregated residential areas had been inseparably linked with the increasing political and economic power of the middle classes, public health policy also reflected and reinforced the idea of segregation.60 Underlying the debate about tuberculosis or about public health problems in general were assumptions, sometimes made explicit, that towns were, by their very nature, socially segregated and that the segregation in Birmingham was not widespread enough. In his study, the Medical Officer of General Dispensary, Dr A. Carver, praised the fact that, in most cases, people in Birmingham moved into healthier neighbourhoods when their incomes rose. "There is none of that clinging to a particular locality, which is so noticeable in the Londoner", he stated.61 The MOH John Robertson was, however, more pessimistic. He pointed out that a large number of well-paid artisans who could have lived in better residential areas put their own and their families' health at risk by living in slum quarters. In defining health problems and constructing policies, the MOH and the Health Committee clearly aimed to regulate the relationship between social classes and urban space and in particular to segregate the 'respectable' working class from the poor.62 In Gothenburg, where a spatial separation of social groups had played a less important role in the political and social development of the city, definitions of urban health problems served to promote social segregation in more subtly ways.

Housing figured prominently in attempts to define the problem of tuberculosis in the early years of the twentieth century in both Birmingham and Gothenburg. However, in Birmingham other preoccupations soon


61 A. E. Carver, An Investigation into the Dietary of the Labouring Classes of Birmingham, With Special Reference to Its Bearing upon Tuberculosis (Birmingham 1914), 21.

62 Report of the MOH on the Unhealthy Conditions, 22-5; Annual Report for 1912, 5-6; Report of the MOH on Child Welfare in 1913 (Public Health and Housing Department, Birmingham 1914); John Robertson, 'The slum problem', Journal of The Royal Sanitary Institute 51 (1930-1), 279-84. However, in his book, published in 1919, Robertson argued that municipal authorities should further social integration: 'One feature which has not yet been generally recognised as desirable in the laying-out of a scheme is the need for housing all classes of the community together, instead of establishing an "east end" and a "west end" in our new areas. John Robertson, Housing and Public Health (London 1919), 75-6. For further discussion, see Patricia Garside, 'Unhealthy areas': town planning, eugenics and the slums, 1890-1945, Planning Perspectives 3 (1988), 24-46; Anthony Sutcliffe and Roger Smith, History of Birmingham. Vol III: Birmingham 1939-1970 (Oxford 1974), 220-32.
SHAPING URBAN SOCIETY

came to the fore and the housing-tuberculosis connection moved into the shade. The concept of the 'unhealthy area' maintained its significance as a major conceptual tool for understanding the problem of tuberculosis, but the attention turned gradually from insanitary houses to other aspects of slum-dwellers' everyday-life - their social contacts, diet, working conditions and their ways of looking after their bodies and treating illnesses - which were believed to make them susceptible to tuberculosis. In 1905, the MOH determinedly looked at the question from this new perspective. While admitting that insanitary housing contributed to the prevalence of tuberculosis, he argued that poor housing conditions were not the main contributory factor in Birmingham. As proof he cited statistics which showed that tuberculosis mortality among women, on whose health the quality of home was expected to exert a particularly strong influence, was much lower than that among men.63

Since male death rates were considerably higher, the MOH often concentrated on examining the factors which could have explained the high prevalence of tuberculosis among men. He argued that the main problems which kept up tuberculosis mortality among men in an industrial town like Birmingham were "bad workshop conditions on the one hand, and public-house drinking on the other."64 However, he always rushed to add that the risk of infection was by no means limited to these situations. In "the unhealthy areas" where people were "ignorant and careless" tuberculosis was ubiquitous. In other words, what was considered to be dangerous was, as Michael Worboys points out, certain kinds of social contact, with certain classes, in certain environments.65 The disease was not only spreading in the homes where poor tubercular patients lived, but the danger was also lurking in any public space - in streets, tram-cars, railway compartments and public houses - where careless patients had been spitting and coughing. The germs of consumption lived in fine dust, "which the slightest breath of air, the foot of a passer-by, the whisk of a lady's skirt, or a crawling infant distributes broadcast to be drawn into the lungs of all who are unfortunate enough to come in contact with it." Furthermore, tuberculosis was highly contagious: anyone could contract it and everyone was potentially ill. Tubercular patients who did not take precautions, so it was argued, infected other people "as certainly as one smallpox patient spreads the disease to those who come in contact with him."66

Unhealthy way of life

As tuberculosis was believed to be ubiquitous in the city and in particular in the unhealthy areas, it did not seem sensible to start hunting down bacilli. The Birmingham authorities maintained that the isolation of

63 Annual Report for 1906, 62-3; Report by the MOH on Consumption, 5-7.
64 Annual Report for 1906, 62-3.
66 The quotes are from Dixon, Lectures on the Prevention of Consumption, 4-5; Report by the MOH on Consumption, 8-9.
advanced cases was not an effective way of preventing the spread of tuberculosis; on the contrary, isolation measures could aggravate the situation by lulling people into a false sense of security. The measures which concentrated on building people's resistance to the disease, on making their bodies inhospitable to infection, would yield much better results. However, the Birmingham authorities made it clear that their own role in building people's resistance would inevitably be limited. The authorities could instruct people in domestic and personal hygiene and carry out some environmental reforms, but ultimately the choice between healthy and unhealthy ways of life would be up to people themselves. Indeed during the preceding decades the Public Health Department had already done much in regard to lessening the number of susceptible people by improving housing and working conditions, by dealing with environmental problems and by checking the quality of food. What had largely been missing, argued Robertson, was a change in people's attitudes and behaviour. Instead of keeping themselves "in such a condition of health as will enable them to resist the invasion of the germ", people increased their susceptibility to infection by their unhealthy way of life.

Health authorities in Birmingham made use of the same scientific results as their Gothenburg counterparts: overcrowding, lack of sunshine and fresh air, want of cleanliness, and malnourishment contributed to the high incidence of tuberculosis. Yet they put a very different interpretation on these results. Instead of concentrating their attention on the tubercle bacillus and pinning their hopes on the isolation of infectious tubercular patients, the Birmingham authorities stressed the role of unhealthy attitudes and behaviours in causing tuberculosis. They pointed out, implicitly or explicitly, that people suffering from tuberculosis were, to an extent, responsible for contracting the disease and for developing the active disease. The Birmingham anti-tuberculosis campaign was clearly permeated with the ethos of individual responsibility.

Bad workshop conditions and drinking in pubs were regarded as major culprits in spreading tuberculosis. These factors were believed to render human 'soil' hospitable to infected 'seeds' and to increase the number of 'seeds' to which individuals were exposed. Firstly, by working in ill-ventilated, dark and damp factories and by "soaking themselves with drink every day" people weakened their resistance to infection. Secondly, in workshops, where people worked in cramped conditions, and in pubs, where they coughed over one other and shared glasses, the risk of infection was believed to be extremely high. Indeed the MOH suggested that drinking combined with ignorance and carelessness played a more important part than bad housing and poverty in causing tuberculosis and many other illnesses.

Furthermore, people had only themselves to blame for their disease, if they spent all days indoors. "(B)y having an abundance of fresh air, which even in the centre of the city costs nothing and is of good quality"
they could have, in most cases, prevented tuberculosis, claimed the MOH in his report. Yet he never elaborated on the fortifying properties of "fresh air", let alone the ways in which these properties assisted the body's defence mechanism in fighting against tuberculosis. Nor did he make any attempt to prove that the air in the city centre was of good quality. In fact, he claimed in another report that numerous factories and workshops which were mixed up among houses in the central wards made the atmosphere "smoky and gloomy, and therefore comparatively sunless." A more analytical approach was taken by the Medical Officer of the General Dispensary, A. Carver, who argued that bad marketing and ignorance of food values paved the way to full-blown tuberculosis in many working-class families in Birmingham. By comparing the weekly diets of 40 'healthy' families and of 40 families in which one or more persons suffered from tuberculosis, he was able to show that tuberculous families did not have as nutritious a diet as healthy families at the same income level. Tuberculous families, he concluded, had spent their money on expensive articles such as beef instead of buying cheap nutritious food and, in consequence, both the overall energy-value and the carbohydrate and fat content of their diet had been too low to protect them from tuberculosis. The value of his research finding was diminished by the fact that his conclusion was based on rather small groups of families and, more importantly, that these families were not chosen at random.

Environmental problems such as defective housing, offensive trades and industrial waste were never left completely out of the picture, but even these problems were often defined in individualistic terms. Running through public health debates in Birmingham was the belief that market forces - and in the 1920s and 1930s the partnership between the market and the public sector - supplied solutions to environmental and housing problems. What frustrated improvements, it was argued, were the individuals involved, who did not make informed choices. The MOH argued that many people were used to their insanitary houses and did not grasp the opportunities offered by the new working-class suburbs. If only these people actively sought better homes and surroundings, insanitary houses near polluting factories and workshops would become impossible to let. Similarly, many people worked in an unhealthy environment, although working conditions were "more or less under the control of the individual. If he thinks his workplace or the character of the work is likely to affect his health he has a remedy in his own hands by leaving the work." Tuberculosis, the argument went, was a disease born of ignorance and of lack of initiative and will-power.

70 Annual Report for 1912, 6.
71 Report of the MOH on the Unhealthy Conditions, 5.
72 Carver, An Investigation. Carver was not alone in thinking that the ignorance of nutritional values of different foodstuffs and bad marketing contributed to the prevalence of ill-health. See, for example, Dorothy E. Lindsay, Report upon a Study on the Diet of the Labouring Classes in the City of Glasgow (Glasgow c.1912), 28-32; D. Noel Paton, 'Introduction' in the above mentioned Report upon a Study on the Diet, 5.
73 See, for example, Robertson, Housing and Public Health; idem, 'The slum problem'. Also, Garside, 'Unhealthy areas'.
74 Annual Report for 1912, 5-6. The quote is from Annual Report for 1924, 29.
Not only were people expected to keep themselves fit to fight off infection, but they were also responsible for managing the cure if they developed tuberculosis. In this respect, the Birmingham campaign differed clearly from its Gothenburg counterpart. In Gothenburg, where a strong current of medical paternalism ran through the anti-tuberculosis scheme, tubercular patients were considered to be almost incapable of improving their situation. Experts, and particularly medical doctors and nurses, went to great lengths to reorganize people's every-day life. In Birmingham, health officials acknowledged that there was room for improvement in housing and working conditions and in medical care. Yet they consistently emphasized that people had responsibility themselves for taking care of their health. If tubercular patients' condition deteriorated, some of the blame had to be born by patients themselves. The basic tenet of the campaign was that the disease could be arrested or cured if patients consulted their doctors once the first symptoms appeared, followed their instructions carefully and adapted themselves to a strict Sanatorium regime. People who did not recover from the disease had, by definition, not taken heed of the advice: they had not sought medical advice early enough or had not obeyed their doctors' instructions to the letter. This line of reasoning grossly understated the degree of difficulty tubercular patients faced. Many of them were likely to lose their battle against tuberculosis whatever they did. If they resigned from their job they were too poor to buy nutritious food and if they continued working they were exhausted.

Rational self-control - the best defence

The Birmingham health authorities were determined to seek both prevention and cure by transforming people's attitudes and behaviour. Education appealed to public health experts and executives for a variety of reasons. Not only were educational measures cheap but they also had the double benefit of improving the health of the population and strengthening the moral fabric of society. Health and social reforms could be united. To justify educational measures, many of which were intrusive, health authorities cited examples of ignorance and carelessness: many tubercular patients seemed to be completely ignorant that their sputum spread the infection, they shared their bed with one or more healthy persons and they were even selling food in shops. With the education which was provided for tubercular patients in both institutions and their own homes many of these problems could be solved. This definition of the problem legitimated municipal intervention in homes, in people's every-day life. At the same time it justified non-intervention or 'selective' intervention in the housing market. Providing houses for the poorest section of the population would not make these people healthier, since the main problem behind their ill-health was ignorance and carelessness.

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75 See, for example, BPRO, HC, minutes 13. 6. 1911 item 3144.

76 BPRO, HC, minutes 22. 9. 1908 item 1358; 19. 4. 1910 item 2383; 26. 4. 1910 item 2397; Godfrey B. Dixon, 'The care of the consumptive in the home', reprint from the Journal of the Royal Sanitary Institute 25 (1914); idem, Lectures on the Prevention of Consumption; Report by the MOH on Consumption.

77 Annual Report for 1905, 65.
Yet the health authorities had no illusion that education would succeed in putting everyone's life in order. The question of how to deal with individuals who did not follow the advice and whose behaviour placed their family or other people at risk provoked serious consideration. On the one hand, the public was encouraged to be vigilant. When the tubercular patient was careless, his friends or neighbours were expected to "either caution him or complain to the authorities of his bad habit." In most serious cases, the health authorities were allowed to use coercive powers to protect the healthy.78 On the other hand, the Chief Tuberculosis Officer complained that tubercular patients were often "treated as lepers of old, shunned by acquaintances, and refused work by employers of labour from a fear of infection."79 If the social consequences of sickness caused greater suffering than the disease itself, people took pains to conceal their illness and, thus, paralyzed the campaign. To allay anxieties the authorities endeavoured to qualify their message by conveying an impression that the problem of tuberculosis, albeit complicated and imperfectly understood, was manageable. Tubercular patients whose habits were 'hygienic' and who lived in an 'hygienic' environment did not pose a serious risk to their families, friends and the public. Patients "with dirty habits", in contrast, were described as being always a danger as though their disease per se would have been more infectious.80

ANTI-TUBERCULOSIS CAMPAIGNS AND URBAN POLITICS

GOTHENBURG

The proposals which the Chief Tuberculosis Officer Gösta Göthlin put forward were couched in explicit acknowledgement that defective housing was the main reason for the prevalence of tuberculosis in Gothenburg and that private housebuilding sector was unequal to the task of supplying the demand for decent housing. He argued that the social costs of the unrestrained market forces far outweighed the benefits of them and that more active municipal intervention in the housing market was necessary to alleviate health problems. What Göthlin proposed was small alterations in the working of the free-market system rather than a radical change, but nevertheless his proposals provoked strong criticism. Until the 1920s the majority of policy-makers in Gothenburg continued to cling to the view that housing reform was best left to the marketplace. Private builders and co-operative enterprises were to build houses and the role of the municipality was,

78 The quote is from Annual Report for 1924, 28. See also, BPRO, HC, minutes 23. 3. 1909 item 1723; 12. 10. 1909 item 2018; 23. 11. 1909 item 2088; 22. 2. 1910 item 2248; 10. 1. 1911 item 2790; 26. 9. 1911 item 3272; Public Health and Housing Committee (PH&HC), minutes 11. 7. 1913 item 1615; Public Health Committee (PHC), minutes 8. 4. 1927 item 10 392; 13. 4. 1934 item 4215; Report on the Spread of Tuberculosis by Indiscriminate Spitting (Health Department, Birmingham 1909); Annual Report for 1903, 28; for 1905, 64-7; for 1912, 39-40.

79 Dixon, 'The care of the consumptive in the home', 500.

at most, to support these agencies.81 In consequence, during the first two decades of the century, little was
done by the municipality to alleviate housing problems which, in Göthlin's words, developed from "acute" in
1913 to "catastrophic" by 1917.82 The deterioration of the housing situation manifested itself very clearly in
the everyday life of many tubercular patients and their families. If the standard of less than 15 cubic metres
per adult and 7.5 per child was used to signify overcrowding, the percentage of tuberculous families living in
overcrowded accommodation rose from 28 to 48 in the years 1913-1916.83

In 1919, the Finance Committee and the Housing Department acknowledged that to resolve the prevailing
housing crisis a net increase of 1,300 flats or single-family houses was needed annually during the following
five years, 1920-24. Both private and co-operative house building being at a virtual standstill, the success in
easing the housing shortage depended largely on the City Council which, in turn, dissipated its time and
energy in fierce debates over whether the municipal intervention was appropriate or not.84 As the debate
dragged on, it became clear that the goal could not be achieved (See, Table 5.1). During the ten-year period
1915-24, the municipality built 1,716 flats and houses, 1,347 of which were let for renting and 369 were
sold. When the Social Democrats managed to consolidate their power in the mid-1920s, public efforts to deal

Table 5.1 Housebuilding in Gothenburg, 1920-24

<table>
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<th>Year</th>
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<th>Demolished houses</th>
<th>Net increase</th>
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<td>52</td>
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<td>75</td>
<td>708</td>
<td>1300</td>
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<td>1300</td>
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<td>1924</td>
<td>1100</td>
<td>169</td>
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81 GSH 1917:14; 1923:113 and minutes and discussion 5. 4. 1923 item 13. Göthlin, 'Reformkrav'; Bertil
Nyström, 'Åtgärder till förbättring av de mindre bemedlades bostadsförhållanden i vissa städer', in Statens
Offentliga Utredningar (hereafter SOU)1935:2: Betänkande och förslag rörande lån och årliga bidrag av statsmedel
för främjande av bostadsförsörjning för mindre bemedlade barnrika familjer, appendix I, 11-4.

82 GSH 1913:337; Göthlin, 'Reformkrav'. For the role of municipalities, co-operative enterprises and private
firms in housebuilding, see SOU 1935:2.

83 Årsberättelse för 1916, 23; GSH 1917:129.

84 See, for example, GSH 1917:14 and minutes and discussion 25. 1. 1917 item 21; 1917:129; 1923:113 and
minutes and discussion 5. 4. 1923 item 13; 1923:328 and minutes and discussion 13. 9. 1923 item 13.
with the housing problem were intensified. However, throughout the period reviewed here, only few policy-makers viewed municipal housebuilding as an answer to the problem of tuberculosis. The factors which primarily prompted the Gothenburg City Council to accept municipal intervention in the housing market were the immediate considerations of class conflict and political strategy, while the concern about tuberculosis and about ill-health in general were clearly of secondary importance. New council houses were not designed for the section of the population among which the death rate from tuberculosis was highest but for more affluent working-class people.

However, the official understanding of the problem of tuberculosis, which centred around homes and the lingering death of infectious tubercular patients, opened up two possibilities for dealing with the problem which were well within the bounds of the implicitly accepted value framework. The definition which emphasized the housing-tuberculosis connection enabled policy-makers to justify, firstly, the institutionalization of tubercular patients and, secondly, the introduction of systematic inspection of all small houses. These policies appealed to many policy-makers for both practical and political reasons. Apart from being relatively cheap, they accommodated conflicting interests and served to further order and harmony in society. These strategies were a kind of compromise: while they included a tacit admission that the housing situation was extremely difficult, they also gave policy-makers an excuse to postpone the discussion about housing problems and in particular about the housing problems of the poorest strata of the society. Furthermore, this view reflected and reinforced the assumption that tuberculosis was chiefly a medical problem. The attention was not focused on poor housing conditions which made people susceptible to tuberculosis but to individuals who were ill and who could infect other people in overcrowded flats.

Segregation of the sick and the well

The first tuberculosis hospital, Hemmet för lungsötsjukar, accommodating 50 'incurable' patients was opened in 1902. This institution was designed for patients who were not eligible for poor relief but who had to be isolated because their illness was highly infectious and because their housing conditions were such as to increase the risk of other people being infected. The main object of the hospital was to break the chain of infection by separating the sick from the well, even though patients were also provided with some basic treatment. The hospital provided food, shelter and medical care for 130-140 patients annually. A large proportion of them, 30-35 per cent annually, died during their stay in hospital, but about 20 per cent were discharged from the "death house" improved and partially capable of working and supporting themselves.

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85 Statistisk årsbok för Göteborg 1925, 111-2; för 1939, 111; Nyström, 'Åtgärder', 1-16.
86 GSH 1900:104 and minutes 6. 12. 1900 item 11; 1902:2 and minutes 23. 1. 1902 item 3; 1902:90 and minutes 5. 6. 1902 item 2; 1902:158 and minutes 30. 10. 1902 item 6; Årsberättelse för 1902, 2-3; Dovertie, 'Åtgärder', 21-2.
87 Årsberättelse för 1903, 2; för 1904, 2, 34-35; för 1905, 2.
The poorest tubercular patients were treated in the poor law infirmary. In 1906, the Poor Law Board opened a special tuberculosis ward with 78 beds for advanced cases. The annual reports of this ward were very similar to those of the tuberculosis hospital. About 35 per cent of patients died annually and 16 per cent were discharged as improved. In the opinion of public health authorities, these arrangements were grossly inadequate to meet the need. At the instigation of Karl Gezelius and seven Councillors, the City Council decided to grant 300 000 crowns from Merchant Sven Renström's donation fund to build a new tuberculosis hospital for patients suffering 'incurable' tuberculosis. This hospital, Sjukvårdsanstalten à Källtorp, which was not opened until 1913, was chiefly designed for working-class and lower middle-class people, but a few private rooms were set aside to accommodate well-to-do patients. From 1909, children suffering from advanced pulmonary tuberculosis were treated in the fever hospital.

As tubercular patients could not be confined to a hospital against their will, health authorities sought to convince them and the public in general that the isolation of infectious advanced cases was best for everyone, important to the well-being of the sick and the healthy. Their point of view was getting across. The queue for hospital beds was long and only a very small proportion of patients discharged themselves from hospital against the advice of the Medical Officer. The 'quarantine' policy was also popular among the public. Many townspeople were suspicious of tubercular patients and sympathetic to the health authorities' persistent attempts to remove as many patients as possible from cramped dwellings and densely built residential areas. Institutionalizing the sick and restricting the rights of people who were sick or were believed to be sick had traditionally featured quite strongly in the Swedish public health policy and did not arouse fierce criticism. Nothing illustrates this more clearly than the health authorities' campaign against venereal diseases and prostitution which went almost unchallenged for decades. This campaign was a drastic intrusion into the lives of individuals, beginning with compulsory medical examinations and ending with confinement in hospitals and enforced labour. Although the Swedish anti-tuberculosis campaign did not resort to such

88 Årsberättelse för 1906, 46.
90 Årsberättelse för 1909, 32; för 1910, 2.
91 Årsberättelse för 1906, 4-4.
92 GSH 1902:90, 6-8; Göteborgs stadsarkiv (GSA), Göteborgs Hälsovårdsnämnd I avdelningen (HVN I), minutes 2. 4. 1930 item 62 and documents K. L.
extreme means of controlling the disease, in practice it also curtailed considerably the rights of a large number of tubercular patients in order to protect the healthy.

**Medical care**

From 1908 the focus of the public health debate shifted to encompass the possibility of curing the disease or, at least, of increasing patients' life expectancy and working capacity. The isolation of advanced cases of tuberculosis remained an important part of the Gothenburg anti-tuberculosis scheme until the 1940s and 1950s, but this strategy was gradually combined with other policies. The discussion which gave impetus for the revision of the scheme in Gothenburg was initiated by the Medical Officer of the tuberculosis hospital, Dr. G. Carlström, who was clearly frustrated with the prevailing rules for access to hospital beds. A number of patients in the hospital, he argued, had overstayed their welcome. Their disease was arrested and they could live for months or even for years, but they would never be able to work and support themselves again. Carlström suggested that these patients should be moved back home or, if there were small children in the family, to the poor law infirmary. Only patients who were dying, who had serious complications or who were responding to the treatment and getting better could be allowed to occupy scarce beds in the hospital. Patients who did not benefit from medical intervention in any way should look elsewhere for care.94

The First City Physician Karl Gezelius, who also advocated a more ambitious medical approach to the problem of tuberculosis, managed to win cautious policy-makers over.95 In the tuberculosis hospital, more emphasis was gradually placed on medical care and, in 1910, the general hospital set aside 50 beds for "acute" cases of tuberculosis. Furthermore, the new tuberculosis hospital, which opened its doors in 1913, admitted not only advanced 'hopeless' cases of tuberculosis but also 'early' and 'intermediate' cases who were provided with sanatorium care. The first Swedish sanatoria, modelled on German public sanatoria, had been established by the state at the turn of the century. These institutions provided tubercular patients with a therapy which combined open-air treatment and health instruction. Fresh air, sun light, healthy diet, regulated exercise and rigid sanatorium regime were expected to work wonders for patients' general state of health and for their chances of recovering from the disease.96 However, by 1913, when the municipal sanatorium was opened in Gothenburg, Swedish health authorities seemed to have lost much of their faith in this type of treatment. More emphasis was placed on restoring sanatorium patients' physical health by providing medical and nursing care and in consequence, the distinction between the sanatorium treatment and hospital treatment

94 Årberättelse för 1906, 44.

95 GSH 1904:189, 10-2; 1907:115

96 John Lundquist, 'Tuberkulosen', in Wolfram Kock, Medicinalväsendet i Sverige 1913-1962 (Stockholm 1963), 383; Puranen, Tuberkulos, 315-6; Weindling, Health, Race and German Politics, 177-81. See also, GSH 1903:141; Berglund, Försäkring mot tuberkulos', 258.
of tuberculosis became blurred in Sweden. Plans to offer open-air treatment had been, to an extent, frustrated by the cold climate and in Gothenburg some medical doctors argued that this form of therapy was impossible even in the summertime, since the municipal sanatorium had been built on marshland where the air was too damp. However, the main reason behind the change in emphasis was the public health officials' ambition to extend the orthodox medical model into the field of tuberculosis treatment.

The confusion between sanatorium treatment and hospital treatment of tuberculosis in Gothenburg and in Sweden in general was symptomatic of the triumph of the medical approach. The medical profession managed to turn the disillusionment with open-air treatment to a great optimism about new forms of therapy which were provided in both hospitals and sanatoria and which consolidated the power of medicine and medical doctors in the anti-tuberculosis schemes. Surgical intervention, collapse therapy, was introduced as early as 1909, although there were serious doubts about its efficacy and abundant evidence of great risks involved. Despite the doubts, not less than 60-70 per cent of Swedish sanatorium patients in the 1920s received this treatment. Tuberculin treatment, which was first used only at the request of the patient, became a more integrated part of patient care during the second decade of the century, and in 1921, the Tuberculosis Officer made a study trip to acquaint himself with a new modification of this method. Finally, vaccine trials in Germany and France were closely followed by the Gothenburg health officials. In 1914, the Medical Officer of the tuberculosis hospital visited Berlin to study Dr. Friedmann's vaccine and in the early 1920s Dr. Arvid Wallgren, a consultant paediatrician at the municipal children's hospital, visited the Pasteur Institute to observe vaccine trials there.

Incentives for innovation and risk-taking

A report on the Eighth International Conference on Tuberculosis in 1908, which was published in Social Tidskrift, emphasized a radical change which was apparently happening in the anti-tuberculosis movement in Sweden.


98 Årsberättelse för 1904, 34-5; för 1906, 42-3; för 1909; 35; för 1914, 50; 'Meddelanden från Göteborgs Läkaresällskaps förhandlingar 9. 3. 1910', Hygeia 73 (1911), Appendix; 11. 3. and 14. 10. 1914, Hygeia 77 (1915), 685, 752-4; 10. 2. 1915, Hygeia 78 (1916), 563-79. See also, GSA, HVN I, minutes 2. 11. 1921 item 239; 4. 1. 1922 item 20: HVN Samfälliga nämnden, minutes 7. 2. 1928 item 9.


100 Årsberättelse för 1904, 34-5; för 1906, 42-3; GSA, HVN I, minutes 2. 11. 1921 item 239; 4. 1. 1922 item 20. Tuberculin was a bacterial product which was derived from a culture of the tubercle bacillus.

101 'Meddelanden från Göteborgs Läkaresällskaps förhandlingar 11. 3. 1914', Hygeia 77 (1915), 685; Årsberättelse för 1914, 50. See also the section 'national campaigns and international trends' in this chapter.
Sweden. The writer pointed out that tuberculosis, which had been chiefly a medical and bacteriological question, emerged in 1908 as an important social question.\textsuperscript{102} However, it is argued here that the role which medicine played in the Gothenburg campaign was not in decline around 1910; on the contrary, health authorities were increasingly preoccupied with medical and bacteriological strategies to deal with tuberculosis. The isolation of advanced cases, surgical operations, the treatment of complications and the development of the vaccine absorbed a large proportion of the resources available to the municipal anti-tuberculosis campaign in the 1910s, 1920s and 1930s. The Gothenburg health authorities clearly believed in the benefits of extensive hospital provision. The governmental Tuberculosis Committee had recommended in 1907 that large towns in Sweden should provide as many sanatorium and hospital beds as there were deaths from tuberculosis annually. With the opening of the new tuberculosis hospital in 1913, Gothenburg achieved the target set by the Committee. In 1914, 388 hospital and sanatorium beds were available for the treatment of pulmonary tuberculosis and 365 people died of the disease during that year.\textsuperscript{103} In other words, there were 106 beds for every 100 deaths from the disease. Markedly fewer beds were available in Birmingham, where municipal and poor law authorities provided 57 hospital beds for every 100 deaths from pulmonary tuberculosis.\textsuperscript{104} Both municipalities received grants from the central government.\textsuperscript{105} In the 1920s and 1930s, neither town improved its sanatorium provision for adults, but in Gothenburg a large number of new beds were provided for children suffering from pulmonary tuberculosis.\textsuperscript{106} Partly because of this reform, there were 175 sanatorium and hospital beds per 100 deaths in Gothenburg in the early 1930s, while in Birmingham there were only 60 beds per 100 deaths.

The important role which medicine played in the Swedish anti-tuberculosis campaign can be partly traced to the strong position which the leading public health experts held in society. They had access to strategic centres of public policy and they enjoyed relatively high a status within the medical profession, within the state bureaucracy and within their own local communities. Achieving good results - reducing the death rate from tuberculosis - was important for them, but their power and status in society clearly gave them considerable latitude. They were able to experiment, to introduce new specialized treatments and technologies and, perhaps more importantly, they were allowed to make mistakes. Hence it is hardly surprising that they often overestimated the effectiveness of their measures and underestimated the risks involved, belittling research findings which were embarrassing to them.

\begin{itemize}
  \item\textsuperscript{102} A. von Rosen, 'Den VIII internationella tuberkuloskonferensen', \textit{Social Tidskrift} (1909), 348-54.
  \item\textsuperscript{103} \textit{Årsberättelse för 1913}, 9; \textit{för 1919}, 19
  \item\textsuperscript{104} In Birmingham, 633 beds were available for the treatment of pulmonary tuberculosis and 1,107 people died from the disease in 1916. \textit{Annual Report for 1916}, 22.
  \item\textsuperscript{105} \textit{Årsberättelse för 1910}, 2.
  \item\textsuperscript{106} \textit{GSH 1910:105} and \textit{161}; 'Sjukvårdsanstalten å Källtorp'; GSA, HVN I, minutes 4. 12. 1918 item 229; \textit{Årsberättelse för 1929 I}, 20-1; \textit{för 1931 I}, 20.
\end{itemize}
Studies conducted in the 1930s suggested that the optimism about the new forms of therapy had largely been misplaced. For example, a study of 6,000 tubercular patients who had been treated in the Gothenburg sanatorium during the years 1910-1934 made for rather depressing reading. Firstly, the study showed that long-term survival rates were poor. More than half of the patients had died within three years after having been diagnosed as suffering from active tuberculosis. Two-thirds had died within five years after diagnosis and not less than three-quarters within ten years. More depressing, perhaps, was the second result that patients' prospects of recovery had not improved during the period 1910-34 despite the vastly increased access to medical care and the introduction of surgical methods. The sharp decline in the tuberculosis mortality from 3.0 per thousand population in 1900 to 0.9 in 1934 was, according to this study, entirely due to the fact that fewer people developed active tuberculosis. However, these research findings did not undermine the Gothenburg anti-tuberculosis campaign or the authority of public health experts. The sanatorium treatment may have failed to provide a cure for tuberculosis, but the Gothenburg health authorities were still able to claim the credit for the declining tuberculosis mortality. They argued that by isolating infectious tubercular patients and by vaccinating children, they had managed to protect a large number of people from tuberculosis.

Inspection of small flats

The integration of housing into the aetiology of tuberculosis also served to justify the introduction of systematic housing inspection in Gothenburg. In 1910, the City Council appointed two women inspectors to visit houses and a Chief Sanitary Inspector to deal with the most complicated cases which required expert knowledge. The purpose of this new municipal agency was twofold: firstly, the inspectors kept a record of small houses (1-2 rooms), carried out routine inspections of these houses and gave advice to the inhabitants as to how to look after their homes and, secondly, they instructed people who were suffering from tuberculosis in necessary precautions and persuaded their family members to seek medical advice and testing. However, keeping all small dwellings and all poor tubercular patients under surveillance soon proved too ambitious an aim for the small organization with three health officials. In the following years, new women inspectors and a medical doctor specializing in tuberculosis were appointed, and in 1915, the housing inspection and the tuberculosis office were separated.

The tuberculosis office developed into a dispensary, a centre of diagnosis and observation from which patients were directed to the most appropriate place, to home, to sanatorium or to hospital. It also provided treatment for tubercular patients who lived in their own homes and sent tuberculosis inspectors to advise patients and

107 Oberg, Läkaresällskap, 143.
109 GSA, HVN I, minutes 3. 10. 1917 item 201; 12. 9. 1923 item 483; Årsberättelse för 1915, 14.
their families. The role that the tuberculosis office played in the anti-tuberculosis campaign became more important over the years, which is discussed in more detail in the last section of this chapter.\textsuperscript{110} Housing inspection, by contrast, was paralyzed for most of the 1910s by the severe housing shortage. Inspectors could not prohibit landlords from letting out insanitary houses, since, in many cases, tenants did not have any other place where to go. The difficulty of proving that a house had an adverse effect on the health of its inhabitants added to inefficiency. The depth of the crisis is sharply illustrated by the fact that in 1916 housing inspectors were able to close only two houses.\textsuperscript{111} Housing problems in the 1920s, though less intense than in the preceding decade, were still of such proportions that inspectors encountered great difficulties in enforcing regulations. They often had to confine themselves to collecting administrative knowledge about small houses and to keeping problem houses under constant surveillance. On a number of occasions, inspectors were accused of treating negligent landlords too leniently, but even their fiercest critics admitted that the inefficiency of the inspection was not the core of the housing problem.\textsuperscript{112}

\textbf{BIRMINGHAM}

The Birmingham anti-tuberculosis campaign was more ambitious an attempt to change people's way of life than its Gothenburg counterpart. While the Gothenburg campaign evoked images of hygienic hospitals and sophisticated laboratories, the Birmingham campaign was marked by an emphasis on individual responsibility. The Birmingham authorities were to carry on the Chamberlain tradition and to give people a better chance of leading a healthy way of life, for example, by providing them with useful information and by building working-class suburbs. However, in the end, the success of the campaign depended on whether the individuals seized these opportunities and adopted new attitudes and ways of behaving. Unsurprisingly, in the campaign, which was motivated by a strong quest to change attitudes, dying patients did not figure prominently. Provision of isolation hospital facilities for people suffering from pulmonary tuberculosis was not raised as an issue until the 1920s and even then it remained of secondary importance. The main emphasis was placed on the education and 'treatment' of patients whose disease was still 'curable'.

\textit{Educational sanatorium treatment}

The central place in the Birmingham anti-tuberculosis scheme was occupied by sanatoria, where 'early' cases of tuberculosis were fortified by different therapies and reformed by health education and orderly, regulated

\begin{itemize}
  \item \textsuperscript{110} Årsberättelse för 1915, 14, 16-8; Årsberättelse för 1927, 15-7.
  \item \textsuperscript{111} GSH 1909:197; Årsberättelse för 1916, 10-1.
  \item \textsuperscript{112} GSA, HVN I, minutes 6. 2. 1929 item 35; 2. 4. 1930 item 62. GSH 1923:328 and minutes and discussion 13. 9. 1923 item 16; 1923:113 and minutes and discussion 5. 4. 1923 item 13.
\end{itemize}
sanatorium life. The sanatorium treatment had been imported to Britain from Germany in the 1890s. Even though the British were somewhat reluctant to acknowledge their debt to Germans, preferring to pay tribute to a little known English doctor who had offered open-air treatment in Sutton Coldfield in the 1840s, the pioneering institutions in Britain clearly emulated private German institutions such as the Sanatorium at Nordach and the Curanstalt at Falkenstein. British local authorities became interested in the treatment in the first decade of the twentieth century. One of the greatest strengths of this form of therapy was that it was not a 'specific' treatment but an umbrella term comprising exposure to fresh air and sun light, healthy diet, regulated exercise and labour, and surgical intervention. Hence health authorities had considerable latitude in reinventing and reconstructing it in the ways which best suited their public health care system and their traditions of treating illnesses. For example, in Gothenburg there was no clear line of demarcation between sanatorium treatment and hospital treatment of tuberculosis, whereas the Birmingham authorities distinguished sanatoria both implicitly and explicitly from hospitals. The main function of the sanatorium treatment in Birmingham was to teach people an orderly hygienic way of life. Surgical treatment of pulmonary tuberculosis, which was widely used in Gothenburg in the 1920s, was not introduced in Birmingham until the 1930s.

Ideally, a British sanatorium was in a rural setting, "in clean bracing country air, away from the smoke of towns and the dust of main roads, sheltered from cold and boisterous winds, elevated, and on a dry soil." It was usually at considerable distance from the city and any railway station, since it was "undesirable to have too many visitors at a sanatorium, as they unwittingly upset their friends." The most commonly used 'therapeutic methods' were open-air treatment, healthy abundant diet, tuberculin injections and graduated exercise and labour which were believed to improve both the patients' general health and their lung condition. However, an essential part of treatment was also strict regulation of life: sticking to the time-table, obeying doctors' instructions to the letter and even avoiding profane language.

The shift from posters and handbills to the establishment of institutions occurred in Birmingham in 1905-06, when the City Council urged the Health Committee to take the matter into consideration. After visiting several institutions, the MOH and Committee came up with the proposal and the Council approved the establishment of a sanatorium in 1907. While the Birmingham decision-makers were considering the sanatorium question, a heated debate was going on in medical journals about the value of this kind of treatment.

113 Salterley Grange Sanatorium (Health Department, Birmingham 1908), 3; Godfrey B. Dixon, 'Progress made in combating tuberculosis', Journal of the Royal Sanitary Institute 48 (1928), 398; Worboys, 'The sanatorium treatment', 53-4.

114 Report by the MOH on Consumption, 26.

115 BPRO, HC, minutes 27. 10. 1908 item 1436; Report by the MOH on Consumption, 15; Annual Report for 1912, 43-4; Salterley Grange Sanatorium, 5-7. See also, Hyslop Thomson, Pulmonary Phthisis: Its Diagnosis, Prognosis and Treatment (London 1906), 77-96.

116 BPRO, HC, minutes 9. 12. 1902 item 7782; 11. 4. 1905 item 9233; 26. 9. 1905 item 9466.
treatment. In both the British Medical Journal and the Lancet some writers called the efficiency of the "mere routine of feed and freeze" into question. They also criticized strongly the way in which the open-air treatment and establishment of sanatoria were justified in Britain, arguing, for example, that "there is no good in importing German statistics into the discussion unless a German climate can also be imported."117 In the opinion of several writers, sanatoria were a complete waste of limited resources.

The medical profession was clearly divided over the value of this treatment and neither side had conclusive scientific evidence to support its stance. Each of the statistical reports claiming that the results of the sanatorium treatment were very good, if not excellent, was disputed by another report asserting that this form of therapy was of little value. Predictably, the treatment was usually endorsed by public health officials or tuberculosis experts who worked in private or voluntary sanatoria, while the blistering attacks came from outsiders, from medical doctors who were not involved in work among tubercular patients and who would have liked limited resources to be invested in other purposes.118 Both the advocates and opponents of the sanatorium treatment were selective, appropriating statistical material for their own political purposes. Thus, the ultimate answer to the question of 'whether generous sanatorium provision would make tuberculosis campaigns more effective' depended entirely on how much trust decision-makers assigned to reports by the advocates and to those by the opponents.

However, providing sanatorium treatment was clearly the way in which both the MOH John Robertson and the Birmingham City Council wanted to deal with the problem of tuberculosis. Furthermore, many local medical practitioners were in favour of a municipal sanatorium, poor law authorities were more than willing to leave municipal authorities to accommodate infectious tubercular patients, and Friendly Societies also urged the Health Committee to provide sanatorium beds.119 The MOH side-stepped criticism levelled in medical journals by arguing that he was fully aware of the reasons why the results of sanatorium treatment had been very ambiguous. In sanatoria which received paying patients proper records were not usually kept, since "such a class of people do not like their cases tabulated." On the other hand, working-class sanatoria, where cases were 'tabulated' whether the people concerned wanted or not, admitted patients in practically every stage of disease and, therefore, results could not be good. The MOH claimed that he knew "of no sanatorium in this country or abroad which is worked on as good lines as it will be possible to work a municipal sanatorium on in Birmingham."120 What was crucial was to admit only such early cases who would be

117 Alexander Don, 'The sanatorium treatment of consumption: is it worth while?' British Medical Journal (hereafter BMJ) 22. 7. 1905, 214. See discussion, for example, the letters from F. Bushnell, Edward Marriott and E. W. Diver, BMJ 15. 7. 1905; from T. Dudfield, BMJ 22. 7. 1905; from J. Halls Dally and Ronald Macfie, BMJ 29. 7; 'The sanatorium and after', BMJ 21. 10 1905; 'The sanatorium and the treatment of pulmonary tuberculosis. The question considered in its therapeutical and economic aspects', Lancet 6. 1. 1906.

118 Worboys, 'The sanatorium treatment'.

119 BPRO, HC, minutes 11. 2. 1902 item 7275; 11. 3. 1902 item 7319; 11. 4. 1905 item 9233; 11. 7. 1905 item 9395.

120 Report of the MOH on Consumption, 11. See also, Thomson, Pulmonary Phthisis, 76-7.
likely to receive permanent benefit by the treatment and instructions offered, and the greatest care was to be taken to keep out all 'incurable' cases. Salterley Grange, which was the first sanatorium in England entirely owned and managed by a municipality, was finally opened in Birmingham in January 1909.

In 1910, the former small-pox hospital was converted to accommodate 'intermediate' cases of TB which were ineligible for admission into Salterley Grange Sanatorium, and after central government's generous capital and maintenance grants became available in 1912 the bed provision was extended further. Dissenting opinions which were published in the pamphlets of the Birmingham Socialist Centre or voiced occasionally in the City Council were not able to change the direction of the policy. Similarly, strong criticism which was still voiced in medical circles both at the local and national level was determinedly rejected. The Tuberculosis Officer claimed that by providing sanatorium treatment also for 'intermediate' cases of tuberculosis, health authorities prolonged these patients' working life for years and reduced greatly their capacity to spread infection. The majority of patients in both sanatoria were discharged "much improved".

The rate of increase in sanatorium beds, accelerated by central governments' favourable attitude and generous grants, peaked in Birmingham in the years 1910-15 and then slowed down during the second half of this decade. The sanatorium treatment was the most important - and certainly the most expensive - feature of the municipal TB-campaign in Birmingham. Since the belief in sanatorium treatment had never been based on compelling evidence of its efficiency, it could not be eroded by reports which suggested that the treatment was grossly inefficient. Hence sanatoria remained an integral part of British anti-tuberculosis schemes until the introduction of chemotherapy in the 1950s. Decision-makers poured money into this form of therapy throughout the first half of the twentieth century, firstly, because they felt that they had to try the 'best' means available to help people suffering from tuberculosis and, secondly, because sanatorium treatment was - or it could be reconstructed to be- compatible with their wider assumptions about how diseases should be controlled and how patients should be treated. However, as in Gothenburg, in the 1920s and 1930s a sense of

121 BPRO, HC, minutes 8. 1. 1907 item 280.
122 BPRO, HC, minutes 12. 1. 1909 item 1575; Salterley Grange Sanatorium, 4-5
123 BPRO, PHC, minutes 28. 2. 1913 item 1224.
124 BPRO, HC, minutes 22. 2. 1910 item 2249; 26. 4. 1910 item 2397; 11. 10 1910 item 2632.
125 BPRO, HC, minutes 12. 7. 1910 item 2536.

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disillusionment and disappointment began to creep into the minds of some health officials who had previously been all in favour of the sanatorium treatment. The Chief Tuberculosis Officer for Birmingham who evaluated the results of the municipal anti-tuberculosis programme in 1928, stated that “there is no indication either for extreme pessimism or excessive optimism.”\textsuperscript{127} With the benefit of the hindsight, it is relatively easy to conclude that neither in Gothenburg nor in Birmingham the results of sanatorium treatment were good.\textsuperscript{128} However, the Birmingham authorities claimed that, although sanatorium treatment did not usually provide a cure for tuberculosis, it could arrest the further development of the disease and prevent people becoming sources of infection. Furthermore, the sanatorium treatment had promoted the healthy way of life in the tuberculous families and in society in general.\textsuperscript{129} Hence their campaign had contributed to the decline in tuberculosis mortality, from 1.4 per thousand population in 1900 to 0.7 in 1934.

\textit{Under pressure to achieve good results}

In Birmingham, health authorities were clearly under considerable pressure to achieve good results. This was one reason why tubercular patients were so strictly categorized. Salterley Grange Sanatorium excluded patients who were not in relatively good physical condition, who were not expected to benefit permanently from the treatment or who had many tubercular cases in their family. By using a strict admission pattern, the health authorities made results look promising. Intermediate cases or early cases which did not respond well to the treatment were treated in Yardley Road Sanatorium. In this institution, the aim was only to prolong patients’ working life and authorities could again show that this aim was achieved. Isolation of chronic and advanced cases did not get much attention before the 1920s.

Conveying an impression that sanatorium scheme worked well was important, because patients had to be motivated to obey the strict sanatorium regime. Many early cases were still capable of leading a relatively normal life. Persuading them to stay for three months in a sanatorium was more difficult than to convince dying or seriously ill patients (in Gothenburg) that the best place for them was a hospital. Secondly, good results were crucial from the tuberculosis officers' point of view. The status of the Birmingham Tuberculosis Officers - and of public health officials in general - was nowhere near that enjoyed by their Gothenburg counterparts. The career of the tuberculosis officer was not prestigious and poor results would have easily appeared as a statement of their professional limitations and failure. Furthermore, since the occupation's status was low, very few medical doctors in Birmingham or in Britain in general took the job of a tuberculosis officer with a view of specializing in tuberculosis. In consequence, they were not particularly

\textsuperscript{127} Dixon, 'Progress made'.

\textsuperscript{128} Bryder, \textit{Magic Mountain}; McFarlane, 'Hospitals'.

\textsuperscript{129} \textit{Report by the MOH on Consumption}, 9-14.
interested in developing the speciality and introducing new therapies.\textsuperscript{130} The problems caused by the low status were discussed also in medical journals. One writer argued that "(u)less sanatorium doctors are put in a satisfactory professional position, as in other countries, the sanatorium movement in Britain will continue to result in economic waste, in ill-digested statistics, and in growing public scepticism."\textsuperscript{131}

Despite doubts and uncertainties, the health authorities clearly managed to convince at least some sections of the public that sanatorium treatment was an answer to the tuberculosis problem. No sooner were sanatoria built than they were filled to overflowing. During the first year, 256 patients were examined and 79 were considered to be 'suitable' cases and were admitted to Salterlay Grange sanatorium.\textsuperscript{132} Yet the campaign did not go as smoothly as the authorities had hoped. Only three months after the opening of the sanatorium, the medical superintendent of the institution was asked to report on why patients left the sanatorium before their treatment was completed. Reasons given were domestic troubles, fear of losing employment and inability to settle down to sanatorium life.\textsuperscript{133} To alleviate financial problems of sanatorium patients, the Board of Guardians were asked to grant as liberal allowances as they could to the dependants of sanatorium patients. The Boards of Guardians promised to be more generous and they adopted a Standing Order which made the full compliance with the suggestions of the municipal health authorities a condition of granting out-relief. Furthermore, the MOH saw all patients before their admission to the sanatorium to make them understand clearly the conditions under which they were received and advantages of a full course of treatment.\textsuperscript{134} These measures did not help. After six months, the medical superintendent had to report that almost 20 per cent of sanatorium patients left before the completion of their treatment. Furthermore, after the First World War, health officials had great difficulty convincing ex-servicemen who suffered from tuberculosis that they would benefit from sanatorium treatment. In Birmingham, 7 per cent of them refused treatment and 11 per cent left sanatoria before completion of the period for which they were advised.\textsuperscript{135}

\textit{With education comes control}

The Birmingham health authorities' determination to build sanatoria did not stem only from the desire to provide treatment for early cases of tuberculosis: sanatoria were considered to be useful themselves and a

\textsuperscript{130} Bryder, \textit{Magic Mountain}, 72-5.

\textsuperscript{131} Ronald Macfie, 'The sanatorium treatment of consumption: is it worth while', \textit{BMJ} 29. 7. 1905.

\textsuperscript{132} BPRO, HC, minutes 8. 2. 1910 item 2229; \textit{Annual Report for 1910}, 4-5.

\textsuperscript{133} BPRO, HC, minutes 12. 3. 1909 item 1694; 23. 3. 1909 item 1731.

\textsuperscript{134} BPRO, HC, minutes 12. 3. 1909 item 1695; 23. 3. 1909 items 1723 and 1731.

\textsuperscript{135} BPRO, HC, minutes 15. 7. 1909 item 1911; Godfrey B. Dixon, 'The discharged soldier and sanatorium treatment', reprint from the \textit{The British Journal of Tuberculosis} (c.1921).
means to a greater end. They were powerful symbols of the healthy, rational and regulated way of life and their influence was expected to extend far beyond the group of people who were actually treated in them. The MOH argued in 1907 that "(p)atients would be returned to the City every year well informed as to the proper treatment of the disease and public attention would be more and more directed to the beneficial effect of fresh air, proper feeding and sanitary surroundings." Sanatoria served to strengthen the very fabric of society.

Alongside sanatorium treatment, which clearly occupied a central place in the Birmingham anti-tuberculosis programme, public health authorities developed some out-patient services, which were mainly educational. They were designed for patients who were awaiting treatment or who had left a sanatorium and for advanced cases who could not be admitted to sanatoria. To direct educational measures at the patients who needed advice, to keep the poorest tubercular patients under surveillance and to intervene in situations where careless and ignorant patients clearly endangered other people's health, the Public Health Department started registering and card-indexing patients. In 1903, it was estimated that about 10 per cent of tuberculosis cases came to the knowledge of the Department through health visitors. These cases were patients who lived in the "unhealthy areas" where health visitors worked. Voluntary notification was introduced in 1904 and in the following year, the MOH estimated that the Department was notified of about 20 per cent of tubercular patients. Almost all of these cases belonged to the "ignorant and careless" section of the population. From 1908, the notification was compulsory for the patients of poor law institutions and from 1912 for all cases.

All notified cases, who were not treated by a private practitioner or a panel doctor, were visited and advised by a tuberculosis visitor. The first tuberculosis inspector was appointed in 1905 and by 1919, 13 health visitors were working among tubercular patients (see also section 5.3). This type of health instruction was made more efficient by ensuring that health visitors and medical officers were invested with authority which was derived not only from their expert knowledge but also from the law. In 1911, the Birmingham City Council approved a by-law which prohibited spitting in streets and other public places. The MOH explained that this regulation, which was modelled on American by-laws, was aimed at limiting "spitting on streets, etc. by consumptives who are in infectious condition. In doing this it appears to me that opportunity should also be taken of reducing at the same time the unwholesome and dirty habit of promiscuous spitting on our foot walks." In order to show that the by-law was not a dead letter, proceedings were taken against a tubercular

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136 BPRO, HC, minutes 8. 1. 1907 item 280.
137 Annual Report for 1903, 28.
138 BPRO, HC, minutes 22. 12. 1908 item 1544; 23. 2. 1912 item 286: Annual Report for 1912, 39-44.
140 BPRO, HC, minutes 26. 9. 1911 item 3272.
141 Report on the Spread of Tuberculosis by Indiscriminate Spitting.
patient soon after the law had been passed.\textsuperscript{142} Furthermore, from 1913, health authorities were able to confine tubercular patients who "wickedly spread... the infection amongst other members of the household" to a hospital.\textsuperscript{143} The Birmingham health authorities were convinced that these control measures would serve to make their educational campaign more efficient.

--- NATIONAL CAMPAIGNS AND INTERNATIONAL TRENDS ---

The last section of this chapter examines the British educational campaign and Swedish 'medical' campaign in the context of the international anti-tuberculosis movement. Most studies of tuberculosis campaigns tend to focus on the formulation of policies at a national level, making little attempt to integrate national strands into international developments.\textsuperscript{144} Yet early twentieth-century campaigns against tuberculosis in Europe and North America were truly an international venture. International conferences, journals and study tours, which became commonplace in the late nineteenth and early twentieth centuries, played an important role in the uptake and rejection of innovations. In these forums, some controversial research findings, procedures and therapies such as sanatorium treatment were accepted as important innovations sometimes without careful analysis of their benefits and costs, and at the same time alternative procedures which could have been equally or more 'effective' were ignored. Similarly, some scientists and research institutes received more than their fair share of publicity and respect, whereas others whose research work might have been of equal quality failed to gain positions of influence.\textsuperscript{145}

Innovations which commanded respect in the international arena did not always sweep through all countries in Europe and North America. On the contrary, it was sometimes in the interests of public health experts and executives to show that the policy they pursued was not influenced by foreign examples. Scientific nationalism along the lines of "only American science could resolve American problems" particularly

\textsuperscript{142} BPRO, PH&HC, minutes 10. 5. 1912 item 481; 14. 6. 1912 item 556.

\textsuperscript{143} BPRO, PH&HC, minutes 11. 7. 1913 item 1615.

\textsuperscript{144} For studies that place national experience into an international context, see Worboys, 'The sanatorium treatment'; Feldberg, \textit{Disease and Class}; Linda Bryder, 'Review of \textit{Disease and Class: Tuberculosis and the Shaping of Modern North American Society} (Georgina D. Feldberg)', \textit{Social History of Medicine} 10 (1997), 194-5.

\textsuperscript{145} For the uptake and rejection of medical innovations, see John V. Pickstone, 'Introduction', and Lindsay Granshaw, 'Upon this principle I have based a practice': the development and reception of antisepsis in Britain, 1867-90, in Pickstone (ed.), \textit{Medical Innovations}, 1-46. For the importance of international conferences, journals and study tours in the decision-making process, see also Marjatta Hietala, \textit{Services and Urbanization at the Turn of the Century: The Diffusion of Innovations} (Helsinki 1987); idem, \textit{Innovaatioden ja kansainvälisyyden vuosikymmenet: Tietoa, taitoa, asiantuntemusta: Helsinki eurooppalaisessa kehityksessä 1875-1917. Vol. 1} (Helsinki 1992); Marjaana Niemi, 'Uudistuva kansakoulu: opettajien kansainväliset yhteydet muutosvoimana', in Kirsi Ahonen, Marjaana Niemi and Jaakko Pöyhönen, \textit{Henkistä kasvua, teknistä taitoa: Tietoa, taitoa, asiantuntemusta: Helsinki eurooppalaisessa kehityksessä 1875-1917. Vol. 3} (Helsinki 1992), 93-182.
informed policy-making in the United States but was by no means restricted to that country. However, the prejudices springing from nationalist sentiments or, for example, from professional enmities were not the only factors which made health authorities wary about some innovations. Sheer prejudice was usually connected to practical political concerns. If an innovation was clearly incompatible with the local policy legacies or with the broader political and social goals which health policy was expected to further, health authorities were likely to reject it, no matter how much empirical evidence was marshalled to prove its efficiency in reducing death rates. An example illustrative of an important innovation which many health authorities found incompatible with their policies and aims was the BCG-vaccine. While some countries introduced the vaccine in the 1920s amid uncertainty and controversies, others still rejected the innovation in the 1930s and 1940s when there was strong evidence that the vaccine lowered the death rate from tuberculosis. This chapter discusses the motives of the Gothenburg health authorities who introduced the vaccine to protect children from tuberculosis, and the motives of their Birmingham counterparts who also sought to protect children but who rejected this new technological fix and clung to their educational approach until the 1950s.

However, nationalistic and selective as health authorities were, the general trend especially in Northern Europe was towards greater convergence. By diffusing innovations and novel approaches across Europe and North America, international networks contributed to a move towards uniformity between national campaigns and, more importantly, towards convergence of western societies in terms of the attitudes to health and disease. The international anti-tuberculosis movement of the 1920s and 1930s was not as powerful a force in legitimating some national policy responses and denouncing the others as were, for example, international AIDS-programmes and organisations sixty years later. Nonetheless it went a long way towards bringing national campaigns closer to each other. The responses to the BCG-vaccine, which offer testimony of many remaining differences between the Birmingham and Gothenburg campaigns, also reveal some important similarities. Both campaigns reflected and reinforced the change in the relationship between society and children, extending the power and authority of public health officials over all (poor) children. Finally, this chapter discusses another international innovation, anti-tuberculosis dispensary, which was less controversial and which reveal areas of powerful congruence between the Birmingham and the Gothenburg tuberculosis schemes.

In both Birmingham and Gothenburg, public health officials had an active interest in the international anti-tuberculosis movement and, perhaps more importantly, a vested interest in contributing to this movement

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146 The quote from Feldberg, Disease and Class, 138.

147 Feldberg, Disease and Class; Pickstone, 'Introduction'. For scientific nationalism and foreign innovations, see also Ian Dowbiggin, 'Back to the future: Valentin Magnan, French psychiatry, and the classification of mental diseases, 1885-1925', Social History of Medicine 9 (1996), 383-408.

and importing ideas from it. Especially in Gothenburg, travel reports, summaries of international research
and various accounts describing procedures in other countries formed a central part of the 'knowledge' on
which decision-makers built their policies. The plans which were put before the Gothenburg City Council
stood, firstly, as an evidence of the health authorities' commitment to follow the lead of, or if possible, to
catch up with the most 'progressive' countries. Secondly, they reflected the determination of the medical
doctors working in this field to consolidate their own position. Specialized international journals, high-
profile conferences, contacts at home and abroad were all important in building up the prestige of the new
branch of medicine nationally and internationally.149

In Birmingham, the attention health authorities gave to ideas which had commanded respect in the
international anti-tuberculosis movement was also rather favourable, differing in both degree and kind from
that they gave to 'foreign' ideas about infant welfare. In developing infant welfare schemes, the Birmingham
health officials often labelled foreign ideas as alien to their traditions and preferred to model their services on
those offered in other British towns. In the case of tuberculosis, importing foreign innovations into
municipal anti-tuberculosis schemes seemed to chime in with the interests of the leading health officials.150
However, their receptivity to foreign ideas was often checked by decision-makers' and central governments'
more sceptical attitude, as the debate about the BCG-vaccine shows.

'PROTECTING' PRE-TUBERCULOUS CHILDREN

BCG-vaccine and different responses

In 1908, French bacteriologists Albert Calmette and Camille Guérin made a breakthrough which, thirteen
years and two hundred trials later, won them the battle for priority in the development of the tuberculosis
vaccine. The public announcement about their success in developing a safe attenuated strain of the bacillus
was made in 1921, and in the following year BCG-vaccine (Bacillus Calmette-Guérin) was administered to
newborns at La Charité hospital in Paris. The news about the vaccine and the apparently successful tests
conducted on infants brought Calmette and Guérin instant recognition in France and much favourable

149 Arvid Wallgren, a consultant paediatrician at the municipal children's hospital, visited the Pasteur institute
in the early 1920s and Anders Wassén, the First City Bacteriologist, in 1926 to follow BCG-vaccine trials. The
Chief Tuberculosis Officer, Gösta Göthlin, studied tuberculin treatment in Germany in 1921. Nurses Hilda Ohberg
and Ruth Hellgren visited dispensaries in London and Amsterdam in 1928. GSA, HVN I, minutes 2. 11. 1921 item
239; 4. 1. 1922 item 20; 4. 4. 1928 item 60; GSH 1926:258.

150 The Birmingham health officials' interest in foreign innovations manifested itself in long study tours to the
Scandinavian countries and the United States. In 1922, the MOH John Robertson visited the United States to
familiarize himself with measures to guarantee a pure (tuberculosis-free) milk supply. The Chief Tuberculosis
Officer, Godfrey Dixon, studied the light treatment of tuberculosis in Copenhagen in 1924 and preventive measures
in the United States in 1927. In the same year, the Assistant Medical Officer of the TB-dispensary visited Denmark.
The MOH H. P. Newsholme made a tour in the Nordic countries in 1931. BPRO, PHC, minutes 26. 5. 1922 item
6915; 22. 2. 1924 item 8140; 8. 4. 1927 item 10 370; 24. 6. 1927 item 10 550; 3. 10. 1930 item 835; 8. 1.
1932 item 2094.
publicity in, for example, French-speaking Canada, Germany and Scandinavia.  

In Gothenburg, the BCG-vaccine was introduced in 1927 by Dr. Arvid Wallgren, a consultant paediatrician at the municipal children's hospital, who had visited the Pasteur Institute to observe first-hand vaccine trials. Wallgren, who was to play a significant role in diffusing this innovation in both Sweden and abroad in the 1930s and 1940s, began work with infants who were born to tuberculous families and who, in consequence, were in imminent danger of infection. Within the next few years, as the evidence of BCG's efficacy and safety mounted, the vaccination programme was extended to include also a number of newborns and children who were not considered to be high risk cases. The results of this study, which Wallgren published in the Journal of American Medical Association in 1934, backed Calmette's claim that the BCG-vaccine was an effective means of reducing tuberculosis mortality.

In 1939, when the Gothenburg health officials next reviewed their vaccination programme, all 1,069 children and young adults vaccinated during the period 1927-37 were called back for after-examination. Again, the evidence that the BCG-vaccine worked was strong but not entirely conclusive. Firstly, 9 per cent of vaccinated children could not be traced, 5 per cent were apparently healthy but unable or unwilling to come to examination and 1 per cent had died (from other causes than tubercular diseases), so the Tuberculosis Officers actually examined only 85 per cent of the vaccinated children. Secondly, and perhaps more importantly, the control group was too small, consisting "at most of some ten (children)" whose parents had not given their consent to vaccination. While admitting the problems in their study design, the Tuberculosis Officers emphasized that these weaknesses did not tarnish the significance of their main result. All 905 cases, including 400 children from high risk tuberculous families, which were examined "were found to be in good health and without any signs of progressive tuberculous disease." This research, albeit not conclusive in the eyes of steadfast opponents, convinced the Gothenburg authorities that their decision to start vaccination trials in 1927 had saved a large number of children and young adults from tuberculosis and that it was justifiable to introduce a more general vaccination policy. During the year 1939 alone, over 600 people were vaccinated.
SHAPING URBAN SOCIETY

Calmette and Guérin had obviously "found warm friends" among Swedish public health officials, but they were also "saddened by the ingratitude of men and the slanders of a few."156 Much of the staunchest opposition to the BCG vaccine came from American and British medical experts who seized on serious flaws in Calmette's study designs as a weapon against him and his vaccine. While Calmette might have been rigorous in his laboratory work, the unsystematic way in which he conducted vaccination trials on infants and presented his results left him vulnerable to severe methodological criticism. Even Arvid Wallgren, who was to become one of the most vociferous advocates of the BCG-vaccine, initially criticized the shaky premises on which Calmette built his arguments, and warmed to the idea of vaccination only when further evidence of BCG's efficacy and safety was provided by other researchers.157 For British and American health officials, who deemed the vaccine incompatible with their anti-tuberculosis campaigns, Calmette's fudged results and bad statistics provided an excuse not to consider the possible benefits of the vaccine. The trials conducted by Calmette, they argued, were so seriously flawed as to render the results meaningless.158

Thus, while health authorities in Gothenburg committed both money and other resources to the BCG-vaccine, sending health officials to France to observe trials, modifying Calmette's study designs and conducting tests on infants, their Birmingham counterparts stood back. In Britain, civil servants in the Ministry of Health and the prominent members of the medical community took either an extremely cautious or openly hostile view of the BCG-vaccine, and the Birmingham health officials, for their part, did not see any reason to question this negative stance and to go abroad to study the issue. Writing in the British Medical Journal in 1931, the Chief Tuberculosis Officer for Birmingham, Dr. Godfrey Dixon, summarized the sentiments of many British public health officials, noting that although 200,000 infants had already been vaccinated world-wide, "Calmette's views as to the freedom from danger of this method of treatment have not been universally accepted. Fears have been expressed that an avirulent strain of bacilli, when injected into the human body, might regain its virulence."159

All children under supervision

Such a marked contrast between the British and Swedish anti-tuberculosis movements was somewhat surprising in view of many common denominators. In the 1920s and 1930s, both British and Swedish campaigns were shaped by growing concern about tuberculosis among children. The shift in focus from adults suffering from pulmonary tuberculosis to children who were either suffering from the disease or

156 Guérin, 'Early history', 35.


158 Feldberg, Disease and Class, 125-75; Smith, The Retreat of Tuberculosis, 194-203; Bryder, Magic Mountain, 138-42.

159 Godfrey B. Dixon, 'Pulmonary tuberculosis in childhood', reprint from the BMJ 25. 4. 1931.
'predisposed' to it was motivated by the same line of reasoning that had paved the way for the introduction of infant welfare services and school medical inspection some years earlier. It was argued that health measures which concentrated on providing medical care for sick adults were treating symptoms rather than the root causes of problems. If health authorities were to succeed in improving the health of the population, they should step up efforts to protect children's bodily health and the morality of their minds.\footnote{Harry Hendrick: \textit{Child Welfare: England 1872-1989} (London 1994), 93-128.} In the case of pulmonary tuberculosis, this conjecture was supported by a number of scientific investigations indicating that those young adults who died of tuberculosis in thousands were just a tip of the iceberg. Many patients who eventually succumbed to tuberculosis in their twenties and thirties had been infected years ago in their childhood.\footnote{\textit{GSH} 1922:398, 3; Dixon, 'Pulmonary tuberculosis'.}

The principal difficulty health authorities faced in preventing and treating pulmonary tuberculosis in children in particular lay in the absence of agreed criteria on who were 'predisposed' to tuberculosis and on who actually had the disease. The tuberculin skin tests and autopsies indicated, according to a report which was published in 1913, that about 90 per cent of the urban population in Britain had at some time suffered tubercular infection. Another frequently cited survey, published in 1930, reinforced this view, suggesting that in European cities an average of 20 per cent of children had been infected by the age of two and not less than 90 per cent by the time they were fifteen. An investigation, which was conducted in Gothenburg during the years 1927-1938, indicated that 40 per cent of children had been infected before they reached the age of ten.\footnote{Sheridan Delepine, \textit{Astor Committee Final Report,} 2 (1913), 27 (cited in Bryder, \textit{Magic Mountain}, 3-4); Richard J. Evans, \textit{Death in Hamburg: Society and Politics in the Cholera Years} (London 1990), 183; Anderson and Belfrage, 'B.C.G. - vaccination at Gothenburg'. See also, Linda Bryder, 'Wonderlands of buttercup, clover and daisies'. Tuberculosis and the open-air school movement in Britain, 1907-39', in Roger Cooter (ed.), \textit{In the Name of the Child: Health and Welfare, 1880-1940} (London 1992), 72-6.}

Clearly, infection with tuberculosis was not synonymous with the development of full-blown disease. But answers to such interconnected questions as who of those infected would eventually develop full-blown disease and what were the most important factors transforming latent tuberculosis cases into active cases were never to be known with certainty. Nor was this all; tuberculosis officers and other doctors had also difficulties defining the point at which the infection became a disease. Distinguishing between children who already had incipient tuberculosis and children who did not have tuberculosis but who tested positive and who were weak, pale and undernourished was sometimes even beyond the capacity of experienced specialists. A wide-ranging study made in Stockholm's municipal primary schools in 1908 sharply reveals the scale of this problem. According to this research, 1.6 per cent of the school children showed some signs of the active disease, and 2.2 per cent were suspected to have tuberculosis but the diagnosis could not be confirmed. A decade later, in 1919, the Gothenburg authorities did not seem to have any clearer view of the problem.\footnote{\textit{GSH} 1919:34, 3-5; G.Kjellin, 'Bekämpandet av tuberkulosen bland barnen', in Alf Gullbring (ed.) Tuberkulosläkareföreningens förhandlingar, \textit{Hygiea} 79 (1917), 1332.}
In 1931, the Chief Tuberculosis Officer for Birmingham published an article in *the British Medical Journal* in which he analysed the difficulties of diagnosing tuberculosis in early childhood.164

In public health rhetoric, knowledge was usually equated with the ability to control diseases and with the justification to intervene in homes and in the private world of the family. But, if necessary, lack of knowledge could also be used to justify intrusive measures. Health authorities in both Birmingham and Gothenburg took a view that drawing a definite demarcation line between the children who were already suffering from tuberculosis and the delicate children who would possibly be affected by it later in their life was not only extremely difficult but also completely unnecessary. It was the interest of the community to keep all these children under supervision, to examine them from time to time and to provide appropriate treatment for them. In order to justify the continuous supervision of children who did not have any specific disease and who had not even necessarily been infected with tuberculosis, health authorities introduced a new clinical category. In Birmingham, children who were thought to be 'predisposed' to tuberculosis were often labelled as 'pre-tuberculous', while the Gothenburg authorities classified them as "children susceptible to TB".165 In both towns, the definition of this category was basically the same as the one used by the British Ministry of Health in its circular in 1927. Pre-tuberculous children were "delicate children who, owing to family history or environment, may be thought to be predisposed to the disease, but who are not definitely diagnosed as suffering from tuberculosis and are not suspected to be actually so suffering."

This vague definition opened the floodgates for municipal intervention, often with unclear objectives and lack of concern for the social and emotional consequences of this policy for families. Decision-makers in both Birmingham and Gothenburg were presented with three potential avenues of controlling the spread of tuberculosis among children. Firstly, infants and young children who still tested negative could be protected from infection by removing them from the environment where the danger of infection was imminent or by vaccinating them. Secondly, more emphasis could be placed on the research finding that infection was not synonymous to active disease and that only a small fraction of those infected eventually fell ill. Looked at from this perspective, it seemed sensible to mount a concerted campaign to strengthen bodily resistance of all children - and in particular of those who tested positive and were weak - so that they would grow up healthy and would not develop the disease. Thirdly, more hospital and sanatorium beds could be provided for the children who were already suffering from tuberculosis.167 Although the order of priorities in Birmingham was again different from that in Gothenburg, policy-makers in both towns deemed all these three avenues worth exploring. With this decision, they gave considerable power to health officials who in the name of

164 Dixon, 'Pulmonary tuberculosis'.

165 BPRO, PHC, minutes 27. 1. 1928 item 10 921; 17. 2. 1928 item 11 003; Åsberättelse för 1916, 22-3; for 1927, 16.

166 BPRO, PHC, minutes 8. 4. 1927 item 10 392.

167 GSH 1922:398, 3; Dixon, 'Pulmonary tuberculosis'.
protecting children from tuberculosis could intervene in many families’ every-day life in the way they saw fit. The extent to which anti-tuberculosis schemes extended and enlarged health officials’ authority over all (poor) children can be illustrated by comparing these schemes to the systems for child care and juvenile justice. Authorities did (do) not only deal with children who were ill, who had shown signs of disturbance or who had committed a crime, but also with children who had not yet fallen ill (pre-tuberculous), who had not yet shown signs of disturbance (pre-psychotic) and who had not yet committed crimes (pre-delinquent).168

**Technological fix or education**

While the Birmingham and Gothenburg authorities shared the aim of keeping both tuberculous and pre-tuberculous children under supervision, there were important differences in the approaches which explain why the Gothenburg authorities followed France in adopting the BCG-vaccine and why the Birmingham authorities chose a different path. The Gothenburg authorities defined the problem of ‘susceptible children’ in a way which enabled them to solve it by official action and medical intervention. At first, in the 1910s and 1920s, health officials saw segregation as by far the best means of tackling the problem, since they considered it an impossible task to protect children in tuberculous families living in small flats. These children, they argued, would suffer tubercular infection at some point no matter how hygienic the homes were.169 The primary strategy was to remove the member of the family who suffered from tuberculosis to an institution. In many cases, however, the tubercular patient stayed at home and children who did not have the disease were boarded out in foster-homes in the country or were sent, temporarily or permanently, to a sanatorium, a colony or a children’s home. The purpose of the latter strategy was often twofold - to remove children from continuous exposure to infection in the home and to fortify their resistance to infection in a ‘healthy’ rural environment.170 In the late 1920s, the municipal dispensary annually arranged holidays for no less than 500-600 pre-tuberculous children and for 150 tuberculous children. More importantly, 150-250 delicate children from tuberculous families were sent to permanent colonies and children’s homes each year. Health officials went about solving this problem in a very systematic way especially in cases in which the mother, too, was suffering from tuberculosis. From the 1920s, mothers were routinely tested in Stockholm’s maternity hospitals and babies of tuberculous mothers were sent to children’s homes or boarded out in foster families. This policy was soon adopted by other municipal authorities in Sweden.171

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170 GSA, HVN I, minutes 4. 12. 1918 item 228.

The policy of removing children from tuberculous homes and keeping them out of the way of tubercle bacilli remained central to the Gothenburg tuberculosis scheme even in the 1930s despite the fact that the vaccination trials had been started in 1927. The popularity of this course of action stemmed not only from health authorities' concern over the spread of the disease but also their desire to ensure the proper socialization of children born to poor tuberculous parents. Yet even the strongest advocates of segregation policy were ready to admit that placing children in children's homes or in the custody of healthy foster-parents was not always a perfect solution. Some mothers categorically refused to be separated from their children, and a growing number of policy-makers supported these mothers, arguing that public health measures should seek to preserve the family ties rather than break them. These considerations had prompted public health experts to follow vaccine trials in Germany and France throughout the 1910s and 1920s. Furthermore, an important attraction of the BCG-vaccine, from the point of view of the public health officials, was that it clearly strengthened the role of science in the Swedish anti-tuberculosis scheme. Modifying Calmette's method of vaccination and conducting trials on infants added significantly to the body of scientific work around tuberculosis, widening the knowledge gap between medical doctors and lay people. In the Gothenburg City Council the proposal to introduce this technological fix passed easily, for it satisfied the practical needs of a large number of decision-makers who wanted to save both lives and money.

In Birmingham, public health officials would have liked to follow, to an extent at least, the same path that the Gothenburg authorities had chosen. The Chief Tuberculosis Officer, stressing that the segregation of infectious tubercular patients and young children would go a long way towards breaking the vicious circle of infection within families, was clearly in favour of more extensive hospital bed provision. Moreover, he argued that some arrangements should be made to remove children - and in particular those who tested positive - "from continuous exposure to infection in the home." After a study trip to the United States in 1927, he pressed his intention by suggesting that the Health Committee should establish a preventorium where children from tuberculous families could be sent. Although the Ministry of Health did not approve the suggested plan for grant purposes, the Committee decided to proceed with it. A month later the plan was, however, rejected and the Committee decided to follow the Ministry's guidelines, which clearly stated that pre-tuberculous children as well as tuberculous children who did not need sanatorium treatment "should be dealt with by Local Education Authorities at Open Air Schools." Holidays for delicate children were arranged by voluntary associations, but these activities were not connected to the municipal anti-tuberculosis schemes.


173 Annual report for 1916, 23; for 1926, 80; Dixon, 'Progress made', 404; Dixon, 'Pulmonary tuberculosis', 10.

174 BPRO, PHC, minutes 8. 4. 1927 item 10 392; 27. 1. 1928 items 10 921 and 10 930; 17. 2. 1928 item 11 003; 23. 3. 1928 items 11 095 and 11 103.
Had the Chief Tuberculosis Officer and other health officials in Birmingham managed to push through the policy, which placed more emphasis on the segregation of the sick and the healthy, the BCG-vaccine would probably have met with a somewhat warmer response. Yet the Health Committee preferred to stay in the mainstream of the British anti-tuberculosis movement, taking measures which were primarily aimed at eroding unhealthy habits rather than controlling bacilli. In Britain as well as in the United States, the fight against tuberculosis was conceived, first and foremost, as an educational campaign. Promoting self-control and providing children and their parents with adequate information about healthy ways of life, it was argued, was not only the best way to build up children's resistance to tuberculosis and other diseases but this approach also created good citizens. The BCG-vaccine was a shortcut; it might save some children from tuberculosis but it did not have the other important virtues of the educational approach. On the contrary, had the vaccine been introduced, people would no longer have been motivated to change their ways of behaving. Thus, while the Gothenburg authorities removed children from tuberculous homes or vaccinated them, the Birmingham authorities considered it better to send pre-tuberculous children to open-air schools to learn healthy ways of life and to breath fresh air. What both authorities ignored was that many pre-tuberculous children were actually malnourished and suffered from deficiency diseases such as rickets or anaemia. Neither the BCG-vaccine nor the open-air school regime treated effectively these conditions.

SUPERVISION OF THE COMMUNITY

Even if, as in the case of the BCG-vaccine, Birmingham authorities' response was sometimes in marked contrast to that of their Gothenburg counterparts, there are many examples of innovations which produced similar reactions from these two quarters. The anti-tuberculosis dispensary is an important and an obvious one. If the Gothenburg and Birmingham tuberculosis schemes had been presented in a chart form, the centre of both pictures would have been dominated by the anti-tuberculosis dispensary. In the context of the diffusion of scientific knowledge, one possible explanation for the similarity of the structures is that health authorities both in Birmingham and Gothenburg were following the same Scottish precedent, an anti-tuberculosis scheme which Dr. Robert Philip had established in Edinburgh in 1887 (See, Figure 5.2.).

By 1910, numerous local authorities and anti-tuberculosis associations in the Nordic countries, Britain, Germany, France and North America had seized upon this idea as a weapon against tuberculosis. In

175 Feldberg, Disease and Class.

176 D. J. Williamson, 'The tuberculosis dispensary - functions and organisation', and Klaus Hansen, Sture Carlsson and Chr. Saugman, 'The movement in Scandinavia and Denmark', in Sutherland (ed.), The Control and Eradication of Tuberculosis, 31-48 and 355-75; Karl Petén, 'Några ord till frågan om patienternas deltagande i arbetet vid folksanatorier', Hygiea 72 (1910), 761-5. See also, Bryder, Magic Mountain, 33-6; Weindling, Health, Race and German politics, 180; Isabelle Grellet and Caroline Kruse, Histoires de la tuberculose: Les fièvres de l'âme,
Gothenburg, the municipal anti-tuberculosis dispensary was established in 1910 and after the First City Physician's visit to Scotland in 1914 it was organised on the same lines as the dispensary in Edinburgh.\footnote{GSH 1908:252; 1909:197 and minutes 28. 10. 1909 § 5; 1917:348, 2-4; Årsberättelse för 1911, 10-3; för 1927 I, 15.} While admitting that they owed the concept of dispensary to the Edinburgh system, the Gothenburg authorities claimed credit for the best implementation of this idea. They argued that Gothenburg was probably the first city in Europe, where Robert Philip's idea - and in particular his idea of a centralized anti-tuberculosis scheme - was fully and logically put into effect.\footnote{Årsberättelse för 1928 I, 23.} It would not be surprising, if this was the case. In Sweden, impediments to centralization were modest compared, for example, with those in Britain, where health authorities had to be careful not to 'encroach' into the territory of general practitioners. In Birmingham, the municipal anti-tuberculosis centre, which was also established in 1910, provided a limited range of services during the first ten years. However, in the course of the 1920s, when more rigid centralism was built into the municipal tuberculosis programme, the scope of services provided by the dispensary was...
In both Birmingham and Gothenburg, the municipal dispensary acted as a clearing house where patients were selected for publicly owned sanatoria and hospitals. As importantly, the dispensary was an outpatient clinic which provided medical assistance and advice for those tubercular patients whose treatment required special knowledge and for a large number of poor patients and in particular for women and children who were neither able to pay for the treatment nor covered by insurance. While the treatment offered by dispensaries and the proportion of the population which used these services varied from place to place, common denominator for these anti-tuberculosis centres in the 1920s and 1930s was that they kept the sections of the community which were considered to be especially susceptible to tuberculosis under close supervision.

The treatment and advice provided in the dispensary was supplemented by frequent home-visits: tubercular patients were visited by a nurse at intervals of a few weeks or several months "according to their needs." Nurses advised patients as to how to convert their homes into "modified sanatoria", beginning with practical living arrangements and ending with 'right' values and attitudes. The home visiting service bore many hallmarks of paternalism, which was hardly surprising, given that the tubercular patients who were visited by health visitors or nurses were usually poor and, at least in Birmingham and Gothenburg, the vast majority of them were women. Health visitors collected a considerable amount of information about patients and their family members, about their circumstances as well as their attitudes and values. Moreover, they often went to great lengths to reorganize the every-day life of these families. The Chief Tuberculosis Officer for Gothenburg noted that "the purpose of these visits is to organize all possible aspects of the patients' life, whether they concern the dwelling, household, child care, finances, employment, treatment or anything else." Besides treating and advising tubercular patients, dispensary staff also made determined efforts to track down consumptives who ignored or tried to conceal early symptoms of the disease as well as people who were considered to be most at risk to succumb to the bacillus.

In Gothenburg in the late 1920s and 1930s, nurses visited annually 2500-3500 homes where someone suffered or was thought to suffer from tuberculosis or be 'predisposed' to it. At the same time, the Birmingham Public Health Department had in their register 6000-7000 homes which were visited. Since the absolute number of deaths from tuberculosis in Birmingham was four times as high as that in Gothenburg and the number of visited homes was only twice as high, the supervision of tubercular patients

179 BPRO, HC, minutes 22. 9. 1908 item 1357; 14. 2. 1911 items 2877 and 2878; 13. 7. 1911 item 3231 and the Report to City Council, 10-11; PHC, minutes 12. 5. 1922 items 6885 and 6886; 28. 3. 1924 items 8151 and 8152; 14. 12. 1928; 8. 1. 1932 item 2094.


181 Årsberättelse för 1912, 11.

182 Annual Report for 1933, 76; for 1935, 88.
seemed to have been more widespread in Gothenburg. One obvious reason for this is that health care system in Birmingham was much more fragmented and a large proportion of people used health care services which were provided by the private and voluntary sectors. Tubercular patients who were treated by a general practitioner were not usually visited by the municipal inspectors. Furthermore, in both towns many families made an effort to avoid the official intervention. In 1927, the Chief Tuberculosis Officer for Gothenburg reported that 25 per cent of people who died from tuberculosis had not been in the dispensary's register. In Birmingham, despite the compulsory notification which was introduced in 1912, many patients managed to conceal their disease with the assistance of their 'sympathetic' doctors who did not divulge the secret which were entrusted to them.

What was the appeal of the close supervision of communities? The main reason for the international success of this idea, health authorities argued, was that the close supervision of home conditions and the aggressive search for early cases was the only effective way of controlling and eradicating tuberculosis. However, what really made this concept attractive to many policy-makers in Sweden and Britain was that it provided an 'apolitical' means of managing social problems such as poverty, overcrowding and defective housing. Although it would be too simplistic to analyze health policies only as a way of dealing with tensions and conflicts, the anti-tuberculosis campaigns went a long way towards alleviating anxiousness about the masses by collecting information about the poor and by making an attempt to reorganize their every-day life.

In the 1980s and 1990s international AIDS-organizations, networks and conferences have legitimated the liberal response to this disease without really discussing the power relationships which this approach reinforces. In the same way international anti-tuberculosis movement accepted and legitimated control measures in the 1920s and 1930s. For example, the anti-tuberculosis dispensary came to be seen as a necessary and unproblematic institution partly because it was an international institution. The assumption that the close supervision of the community and aggressive search of tubercular patients contributed to the decline of tuberculosis mortality assumed the mantle of an unchallengeable universal truth and these activities continued to be clothed with the public interest throughout the 1920s and 1930s. It was rare for anyone to question the efficacy of this policy and to suggest alternative approaches.

CONCLUSION

The comparison of the Birmingham and Gothenburg anti-tuberculosis campaigns shows that scientific knowledge about tuberculosis allowed widely different definitions of the disease. In Gothenburg, where medical doctors played a dominant role in constructing the public health policy, tuberculosis was largely seen as a bacteriological and medical problem. Efforts to curb the ravages of the disease focused, firstly, on

containing the spread of the bacillus. Infectious tubercular patients were isolated from the rest of society, and children born to high risk tuberculous families were boarded out in healthy foster-homes or were vaccinated against the disease. Secondly, interventionist medicine, which required specialized skills and thus enhanced the professional status of tuberculosis physicians, took precedence over conservative methods in the actual treatment of tubercular patients. The Gothenburg campaign against tuberculosis was first and foremost a battle against the bacillus fought by experts - scientists, medical doctors and nurses - in sophisticated laboratories, in hygienic hospitals and in the homes of tubercular patients. The efficiency of the campaign was increased by instructing people in the healthy way of life, but the educational measures were always subordinate to the medical and bacteriological strategies. The 'bacillocentric' view of this type justified control measures which could drastically circumscribe the rights of individuals. On the other hand, the campaign which assigned responsibility for disease prevention to experts did not, in principle, blame ill-health on individuals. The bacillocentric approach served to make tuberculosis impersonal.

In Birmingham, where medical doctors were less influential in shaping the public health policy, unhealthy habits rather than the bacillus were seen as the primary cause of tuberculosis. In particular the blame for the disease was placed on alcoholism, poor diet, lack of fresh air and the low standard of personal and domestic hygiene which were all believed to weaken the body's own defence mechanism. In consequence the Birmingham anti-tuberculosis campaign focused on instilling in people a sense of responsibility and on instructing them in healthy habits. Interventionist medicine in the treatment of tubercular patients did not gain widespread popularity in Birmingham until the 1930s and the BCG-vaccine was rejected as 'unsafe'. The educational approach appealed to the Birmingham policy-makers for a variety of reasons. Firstly, educational measures were broadly in line with the British public health traditions. Secondly, the career of the tuberculosis officer was not prestigious in Birmingham or in Britain in general, and so many tuberculosis officers concentrated their efforts on finding another job rather than on experimenting and introducing new therapies. Thirdly, the BCG-vaccine, the isolation of advanced cases and interventionist medical treatment were seen as measures which could lull people into a false sense of security. Solving the problem of tuberculosis demanded nothing less than personal behaviour change. Control measures did not figure in the Birmingham campaign as prominently as in the Gothenburg campaign. However, the Birmingham campaign which concentrated on unhealthy habits inevitably blamed tubercular patients for their disease. The educational approach served to make tuberculosis personal.

Although there were great differences between the Birmingham and Gothenburg anti-tuberculosis campaigns, policy-makers in both cities had based their campaigns on 'apolitical' facts provided by science. Moreover, the conclusions which they had drawn from these apolitical facts were equally logical (or equally illogical). Scientific knowledge about tuberculosis could be reconstructed to justify both the educational approach and the medical approach. Furthermore, the death rate from tuberculosis declined sharply in Gothenburg and Birmingham during the period reviewed here and thus the health authorities in both cities were able to proclaim the success of their methods (Fig. 5.3).
These two anti-tuberculosis campaigns, which both could be defended as scientific, rational and successful, clearly reflected the interests of the medical profession but they also advanced other important political aims. Firstly, they served to maintain social order in cities by justifying official intervention in 'problem homes' and health promotion which involved constant record-taking, measuring and screening. In Birmingham, official intervention was justified by 'showing' that the main cause of tuberculosis in the "unhealthy areas" was ignorance and carelessness. The Gothenburg authorities, in contrast, argued that municipal intervention in homes, and in particular in small insanitary houses, was necessary to contain the spread of the bacillus.

Secondly, the anti-tuberculosis campaigns served to regulate the local economy by legitimating intervention or non-intervention in the housing market. When the health and housing authorities sought to justify municipal housing projects, they emphasized how crucial decent housing was for the health of the population. However, more often than not, they were determined to show that health could be secured without major changes in the housing market. Justifying non-intervention was politically important. Colin G. Pooley, who has looked at different housing strategies pursued in European countries in the early twentieth century, argues that while all main strategies provided good quality housing for more affluent working-class households, they failed to provide a solution to the problem of housing provision for those on genuinely low incomes. ¹⁸⁴ This was clearly the case in both Birmingham and Gothenburg. In Birmingham the poorest section of the population, among which tuberculosis mortality was high, still lived

in insanitary back-to-back houses in the late 1930s. The health authorities justified their non-interventionist policy by arguing that unhealthy habits, not defective housing, were making people sick in these unhealthy areas. In Gothenburg the poorest section of the population lived in overcrowded small flats throughout the period reviewed here. Public health experts and executives acknowledged that small houses and tuberculosis were a dangerous combination, but they 'solved' the problem by removing infectious patients to hospitals, not by improving housing conditions. When tubercular patients were removed from their wider social context into a hospital, they became 'cases' and the circumstances in which they had lived and worked were no longer interesting. The problem of slum houses had been shelved in both Birmingham and Gothenburg, and the way in which the problem of tuberculosis had been defined had given the policy-makers a perfect excuse to do so.

When it came to the question of tuberculosis and the family, the Birmingham and Gothenburg health authorities chose different paths. The Birmingham anti-tuberculosis campaign clearly reinforced the rights and responsibilities of biological parents, exhorting them to look after their children. In Gothenburg, in contrast, the mechanistic medicine and wide-ranging welfare calculations circumscribed the rights of biological parents and, in many cases, overrode the wishes of tubercular patients and their families. For example, mothers who were suffering from tuberculosis were often separated from their children. The main aim was that children would live in 'healthy' homes and in healthy environment. Whether they were taken care of by their biological parents was of secondary importance.
CONTESTING AUTHORITIES' VIEWS

"There is only a certain amount of human energy in this city. Most of this goes in private money grubbing, much in amusement, some in churches, charity and petty, selfish politics. There may not then be enough brain and public spirit left over to respond to the Socialist statement of economic diseases and their remedies.

J. A. Fallows, The Housing of the Poor (1988)\(^1\)

As the case studies in the preceding chapters illustrated, public health campaigns were, to an extent, political answers to political problems. The ways in which authorities defined health problems and responded to them usually served to preserve and legitimate existing economic and social arrangements in cities. However, the definitions of health and disease could also challenge prevailing structures and become a vehicle for social change. Much was at stake, and yet feelings rarely ran high. In the early twentieth century the vast majority of health questions aroused neither political anger nor moral uproar. For example, political parties rarely placed health and environmental issues high on their agendas, since these questions were not likely to bring immediate political dividends. Campaigning for sound sewers or a new maternity hospital was not seen as an efficient way of attracting votes, either of the middle-class or the working-class.

This is not to say that politicians and health officials were unaware of the political potential of health questions. Health measures formed an integral part of the welfare reforms on which many Liberal and Conservative politicians pinned their hopes when they sought to further social peace. Among the prominent British politicians who recognized the value of social reforms in strengthening the existing economic and political order was Joseph Chamberlain. At his instigation the Birmingham Corporation used municipal powers in a most conspicuous way for social improvement, and in the national policy arena Chamberlain strongly advocated redistributive state welfare. In Sweden, similar ideas were promoted by S. A. Hedlund and Henrik Hedlund, Liberal politicians and the editors of the main daily newspaper in Gothenburg.\(^2\) Furthermore, many employers saw welfare programmes as a valuable asset. In the early twentieth century, a

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\(^1\) J. A. Fallows, The Housing of the Poor (Birmingham 1899), 16.

large number of Swedish companies sought to harmonize industrial relations by contributing to sick funds and by providing medical care for their employees, and many leading British businessmen, like German businessmen earlier, actively encouraged the state to introduce national health insurance. In the 1930s, 1940s and 1950s influential business groups in both Sweden and Britain participated in the political bargaining processes which institutionalized 'Keynesian' policies and wide-ranging welfare programmes. Finally, medical doctors were acutely aware of one political aspect of health care. When the details of important health reforms were being negotiated, at the heart of the debate lay not only the health of the population but also the economic security and professional status of the medical profession.

Yet at the level of day-to-day policy-making, in the meetings of Public Health Committees, Child Welfare Committees and City Councils, the political potential of health measures was much more dimly, if at all, perceived. In analyzing urban health problems, in operating infant welfare centres, in running tuberculosis sanatoria and in launching vaccination campaigns, few public health executives and experts consciously viewed their activities as serving the interests of the middle-class, men, the medical profession or the existing political and economic arrangements. They saw their responsibility as investigating health problems and sorting out solutions which would be within the budget and broadly in line with the latest medical knowledge, and which could be welded onto existing municipal services. They may have been conscious of some assumptions on which they based these solutions, but certainly not of all of them.

Health reforms did not arouse much political passions on the opposing side either. Those who attacked existing political and economic order usually chose to voice their discontent in the domain of political

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4 Helen Mercer et al. argue that "the period of the post-war Labour governments has been identified as one where the influence of the FBI (the Federation of British Industry) with government, in terms of constant contacts and routine consultation, reached an unprecedented and not-to-be-repeated peak." Helen Mercer, Neil Rollings and Jim Tomlinson, 'Introduction', in Helen Mercer, Neil Rollings and Jim Tomlinson (eds), *Labour Governments and Private Industry: The Experience of 1945-1951* (Edinburgh 1992), 1-11, the quote, 7. See also, A. A. Rogow, *The Labour Government and British Industry 1945-1951* (Oxford 1955); Lindqvist, *Från folkrörelse till välfärdsbyråkrati*, 78-104; Margaret Weir and Theda Skocpol, 'State structures and the possibilities for "Keynesian" responses to the Great Depression in Sweden, Britain, and the United States', in Peter Evans, Dietrich Rueschemeyer and Theda Skocpol (eds), *Bringing the State Back In* (Cambridge 1985), 112-3.


6 For the unintentionality of social control, see for example, Howard Waitzkin, 'A critical theory of medical discourse: ideology, social control, and the processing of social context in medical encounters', *Journal of Health and Social Behaviour* 30 (1989), 220-39.
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economy rather than in the field of public health, even though there were some important exceptions to this rule. In the late nineteenth and early twentieth centuries, radical left-wing groups in many European countries were strongly opposed to municipal services and in particular to state welfare which they conceived as a strategy to protect capitalist society. David Barnes, one of the few historians to analyze the extent to which radical groups contested the central tenets of the mainstream medicine, argues that revolutionary syndicalists in belle époque France rejected the dominant aetiology of tuberculosis and developed alternative understanding which was both coherent and medically sophisticated. The syndicalists claimed that the existing efforts to fight tuberculosis were ineffectual, since they were directed at the superficial manifestations of the disease. If the campaign was to succeed, efforts should be concentrated on tackling poverty and overwork and - in the long term - on overthrowing the capitalist system.\(^7\)

More moderate working-class organizations in France and in other European countries rarely went so far as to question the dominant aetiology of diseases, but municipal and state welfare amounted to a mixed blessing also for them.\(^8\) In addition to leftist groups, women's organizations questioned occasionally the motives of health and social policy. Lynn Karlsson and Anna-Birte Ravn show that in Sweden and Denmark female members of the Social Democratic Parties and trade unions joined forces with middle-class feminists to campaign against a ban on night work that applied to women only. They argued that the ban which was introduced to protect the health of women and children would buttress the dual, gender-based labour market and therefore it would only add to the hardships many women and children already suffered.\(^9\) Swedish women's groups presented a united front also against plans to prevent married women from working.\(^10\)

However, debates about the political implications of health and welfare measures were usually limited to small circles of feminists and left-wing socialists. Most people saw health policy not as part of wider political drama but as measures which either alleviated or aggravated their immediate problems. Health reforms which improved access to medical care were welcomed by a large proportion of working-class people and middle-class women despite the ideological messages doctors always conveyed in their encounters with clients. On the other hand, routine medical inspections which many people considered unnecessary and

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\(^9\) Anna-Birte Ravn, "'Lagging far behind all civilized nations:' the debate over protective labor legislation for women in Denmark, 1899-1913", and Lynn Karlsson, 'The beginning of a "masculine renaissance: the debate on the 1909 prohibition against women's night work in Sweden', in Ulla Wikander, Alice Kessler-Harris and Jane Lewis (eds), *Protecting Women: Labor Legislation in Europe, the United States, and Australia*, 1880-1920 (Urbana 1995), 210-34, 235-66.

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health visiting which entailed 'intrusion' into working-class homes were less popular, at least initially. Since all these three services conveyed basically the same ideological messages, different reactions could not be due to ideological messages per se but to the ways in which the messages were put across. People tended to accept measures that appeared to make a significant difference in their immediate well-being, while they took more critical attitude to services which were not likely to confer any immediate improvement or which they saw as punitive and intrusive. Critical views, which were not uncommon in the early years of the twentieth century, diminished considerably in the period 1910 to 1940. Municipal services seemed to be increasingly successful in winning the approval of both working-class people and middle-class women.11

What insulated public health policy from political contention and conflicts? The most effective shield against political criticism, as the preceding chapters showed, was the authority of science. Statistical tables, charts and maps that health officials used to illustrate public health questions were produced by applying sanctioned scientific methods and therefore they were usually accepted as unproblematic and value-free. Reports in which health officials analysed problems such as infant mortality and tuberculosis by utilizing the latest findings of contemporary science were not seriously questioned. The view that the basic tenets of public health campaigns were apolitical and value-free was widely shared by both policy-makers and the public. Secondly, it was generally accepted that the health of the population would improve if individuals and society as a whole conformed to this true knowledge about health and illness.12

By using the authoritative language of science, health authorities placed, wittingly and unwittingly, many health issues beyond the reach of political argument. Another factor that helped persuade the public and win their sanction to health measures was the ambiguity of public health policies. No matter how coherent and internally organized the policy appeared to be, it was always fissured by competing interests and aspirations. Owing to these contradictions, health policy was compatible with a variety of political perspectives. People subscribing to very different 'world views' - conservatism, socialism, militarism, feminism and humanism - could all feel that health policy reflected, to an extent, their values and interests.13 Furthermore, all groups involved in policy-making, both the old power blocks and the relative newcomers, working-class men and women of all classes, could see that they got at least some of the things for which they had battled. In examining the welfare reforms introduced in Britain between 1906 and 1914, David Vincent makes the same


point. He claims that "most Labour MPs saw (these reforms) as a stepping-stone towards something much better, and many Liberals regarded them as a bulwark against something much worse."\(^\text{14}\)

Finally, a factor which often saved health authorities the trouble of justifying their policy decisions was that public health campaigns were far from alone in promoting new attitudes to looking after one's body.\(^\text{15}\) During the period reviewed here, from the 1890s to the 1930s, stimuli and pressures for adopting 'modern, rational and healthy' way of life came not only 'from above', from health campaigns, private and public welfare systems and elementary education but also 'from below', from working-class organizations, women's groups and popular movements. Alfons Labisch and Sabine Schmitt show that the German Social Democratic Party, sceptical though it was about the existing health measures, placed a high premium on the safeguarding of health in the late nineteenth and early twentieth centuries. The party demanded, for example, free medical care and legislation for 'protecting' women workers and for barring married women from the labour market. Thus it contributed to the medicalization of the working class and to the ordering of society along gender lines as did the early twentieth-century social hygiene movement.\(^\text{16}\) Though more concerned with popular movements than with political organizations, Jonas Frykman's study on the socialization process that transformed "peasants into Swedes" does touch on the same theme. Frykman claims that if the process of discipline and 'civilization' is only examined as a process initiated from below and accepted down below, the rapid modernization of the Nordic countries in the interwar years remains partly unexplained: "Being on the fringe of Europe, they received new ideas from the Continent and England rather late. Still people were more thoroughly disciplined - in Foucault's sense of the word - than any comparable nation in Europe." Sweden, concludes Frykman, owed its modernity at least as much to popular endeavours like Swedish gymnastics as to public health campaigns or to elitist debates about functionalism.\(^\text{17}\)

The fact that these movements and organizations promoted similar way of life to that advocated by health authorities should not necessarily be seen as evidence of internalization of bourgeois norms or, in case of women's organizations, of dominant male ideologies. One and the same means could be used to pursue different - even competing - goals. This point is clearly illustrated by studies on the Swedish and Finnish temperance movements. Temperance groups which had great appeal to large sections of rural population and

\[\text{\textsuperscript{14}} \text{David Vincent, } Poor Citizens: The State and the Poor in Twentieth-Century Britain (London 1991), 38.\]

\[\text{\textsuperscript{15}} \text{Reinhard Spree, Soziale Ungleichheit vor Krankheit und Tod: Zur Sozialgeschichte des Gesundheitsbereichs im Deutschen Kaiserreich (Gottingen 1981), 138-62.}\]

\[\text{\textsuperscript{16}} \text{Sabine Schmitt, } Der Arbeiterinnenschutz im Deutschen Kaiserreich: Zur Konstruktion der Schutzbedürftigen Arbeiterin (Stuttgart 1995); idem, "All these forms of women's work which endanger public health and public welfare": protective labor legislation for women in Germany, 1878-1914", in Wikander, Kessler-Harris and Lewis (eds), Protecting Women, 125-49; Labisch, 'Die gesundheitspolitischen Vorstellungen'; idem, 'Das Krankenhaus in der Gesundheitspolitik'; idem, 'Doctors, workers and the scientific cosmology'.\]

urban working-class campaigned vigorously for "liquor strikes" and teetotalism and for thrift and orderly life. Yet they also provided a strong rhetoric and a firm organizational basis for oppositional politics.18 For temperance members, most of whom did not have the vote in the early years of the twentieth century, temperance was part of the struggle for the political suffrage of the respectable "small folk" and against the power of the "immoral" elite. An analogous conclusion is drawn by Pat Thane who has looked at the benefit regulations of British trade unions and friendly societies and at the definitions of 'deserving' and 'undeserving' poverty these regulations reflected. She points out that working people's own definition of 'deserving' poverty was often similar to the norms followed by middle-class philanthropists, since "(s)uch values as hard work, sobriety, discipline, loyalty and respect for sacrifices of fellow workers were as essential to a successful worker's movement as to successful capitalism."19

This chapter explores how health authorities' views were contested in Birmingham and Gothenburg. In particular, the chapter focuses on layers of consensus and conflict in the discussions which concerned infant mortality and tuberculosis. What is evident is that middle-class women and working-class women and men were all aware, to an extent, that health policies advanced different aims. It was not only about the health of the population but also about wider economic and social concerns. The chapter discusses how these groups articulated their demands and how they impressed their views on other groups and on decision-makers. How did they use contradictions in health policy to mobilize their own power and to change the policy?

MIDDLE-CLASS WOMEN AND INFANT WELFARE

Voluntary agencies, which for many women were the only arena for exerting influence on wider social issues, were often critical of existing health policies. Yet most of these organizations were either unable or unwilling to mount an open challenge to health authorities. Hence by looking exclusively at political disputes over health issues in the early twentieth century, one tends to get an impression that women widely accepted the ways in which authorities defined health problems. However, the burgeoning literature on women's voluntary efforts and the rise of the welfare states have shown that women often shaped health campaigns not by protesting against the official perceptions but by creating new innovative services which, in their opinion, answered the needs of women and children better than the existing services.20


19 Thane, 'The working class', 884.

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The extent to which women were able to influence the content of health and welfare services varied from country to country. Seth Koven and Sonya Michel have argued that "weak states" such as the United States and Britain allowed middle-class women more political space in which to develop social welfare schemes than did "strong states" such as Germany, France and Sweden.21 This theory explains important aspects of the emergence of welfare policies and in particular the impact of organized women's movements on the process in different countries. However, Nordic feminists have regarded this model as too restrictive and have distanced themselves from the hostile attitude towards the state, which Koven and Michel, among many other American feminists, have taken.22 In the "strong" Nordic states, where policy-making structures were centralized and experts were influential in constructing policies, middle-class women's voluntary associations tended to have relatively little influence on the direction and form of the campaigns. Therefore, in order to examine whether middle-class women were able to shape health and welfare policies in the Nordic cities, one has to look at women's reform activities in both the public and voluntary sectors. Women who were most likely to have influence on health policies in Nordic cities were not "philanthropic ladies" but, for example, female medical doctors who worked in both the public and voluntary sectors. This chapter discusses middle-class women's reform activities and infant welfare campaigns in Birmingham and Gothenburg. In particular, the chapter looks at how women were able to shape infant welfare campaigns in these cities and how the role they played was affected by local government structures and policy legacies. Were middle-class women less influential in shaping infant welfare campaigns in Gothenburg where policy-making structures were centralized than in Birmingham where political and social arrangements were more localized and fragmented?

PHILANTHROPIC LADIES AND POOR MOTHERS: BIRMINGHAM 1900-20

The elite in nineteenth-century Birmingham may have generously given their time and money to various charitable activities, but health education and sanitary improvements were clearly not among the most popular objects of philanthropy.23 From the 1870s on, the Medical Officer of Health (MOH) for Birmingham, Dr. Alfred Hill, tried in vain to encourage local "philanthropic ladies" to follow the example


23 For philanthropic activity in Birmingham, see Derek Fraser, *Power and Authority in the Victorian City* (Oxford 1979), 102.
set by the Manchester Sanitary Association. The Ladies' Branch of this association had inaugurated a system of health visiting in order to advise working-class women on domestic hygiene and child care. In Hill's opinion, this kind of service, organised by a voluntary society, was exactly what was needed to reduce infant mortality in Birmingham.24 By 1899, however, no voluntary society had taken it upon itself to organize the work, and in consequence the Birmingham Health Committee appointed four municipal health visitors.25 The attempt to persuade middle-class women to establish milk depots was not successful either. The Birmingham Ladies' Association for Useful Work, on which the MOH pinned his hopes, replied in 1899 that organizing a system of milk distribution was "quite beyond the powers and resources" they had.26

Yet during the first decade of the twentieth century, attitudes among middle-class women were clearly beginning to change. Many women who had been thinking that alleviating urban health problems was not within the compass of their charitable work became convinced that their contribution to infant welfare movement was indispensable. This change in attitude was soon reflected in the work of many old and newly established voluntary societies in Birmingham. In 1916, voluntary agencies ran seven maternity and infant welfare centres, arranged sewing and cooking classes in municipal centres, kept two nurseries, supplied meals for pregnant and nursing mothers, organized training courses for midwives and provided hospital beds for maternity cases.27

The first and most influential of the societies which concentrated exclusively on the health and welfare of infants was the Birmingham Infants' Health Society (BIHS) which was established in 1907. What distinguished this society from other similar organizations in Birmingham was mainly the skilful way in which it secured the staunch support of the municipal health authorities, general practitioners and influential local families such as Chamberlains, Kenricks and Cadburys. Furthermore, in their everyday work among infants and mothers the BIHS co-operated closely with the Public Health Department. In 1908, the society established an infant consultation clinic in St. Bartholomew's Ward, an area housing some of the poorest people and with one of the highest rates of infant mortality in the city.28 A few months later, the Public
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Health Department opened a clinic to serve two other poor areas, St. George's and St. Stephen's Wards. The services provided by these two baby clinics, voluntary and municipal, were basically similar, ranging from medical supervision of infants to health visiting and cookery lessons. However, the obvious similarities veiled some important differences. By comparing the ways in which the Health Department and the BIHS defined the problem of infant mortality, the next section examines, firstly, how middle-class women were able to influence the infant welfare campaign and ultimately the municipal health policy in Birmingham, and secondly, whether these women at the same time created new roles for themselves in policy-making.

Challenging the official perceptions

Rather than just accepting the MOH's definition of the problem of infant mortality, medical doctors working for the BIHS set about to study the question. As with the MOH, their point of departure was the finding that babies who were breast-fed had a far greater chance of survival than those who were given cow's milk. But whereas the MOH and Health Committee were chiefly working on the assumption that maternal ignorance and married women's employment were the main contributory factors to the prevalence of bottle-feeding and therefore to the high rates of infant mortality, the BIHS doctors were more interested in examining the extent to which bottle-feeding in such areas as St. Bartholomew's Ward were attributed to poverty. The doctors claimed that "half-starved mothers," some of whom lived only on tea and toast, were not able to produce a good quality and quantity of breast-milk. Thus a vast majority of babies who were brought to infant consultations in St. Bartholomew's Ward were "of inferior physique." Babies who were weaned early or for whom breast-milk was supplemented with other foods were doubly disadvantaged, but even breast-fed babies were weak and small, their weight being clearly below normal.

The answer to the problem of infant mortality, the BIHS doctors argued, was to encourage all mothers to breast-feed and to provide free meals for nursing mothers who lived distinctively below the poverty line. The BIHS started supplying meals on a small scale in 1908 and from 1913 the provision of meals was organized in association with other voluntary organizations. Furthermore, the BIHS advocated infant milk depots, even though it never established one. The medical doctors working for the society pointed out that breast-feeding might have been the ideal, but in reality a significant proportion of infants, about 30 per cent in St. Bartholomew's Ward, had to be bottle-fed for one reason or another. Thus some special measures

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29 BPRO, HC, minutes 19. 2. 1908 item 1001; 14. 4. 1908 item 1109; Annual Report for 1907, 17; Jessie Duncan, Report on Infant Mortality in St. George's and St. Stephen's Wards (Health Department, Birmingham 1911).


31 BIHS, Report for 1908, 8; for 1912, 22-3; for 1913, 14, 25; BPRO, Birmingham Maternity and Child Welfare Sub-Committee (M&CWSC), minutes 4. 2. 1916 item 36.

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should be taken to protect these children and "in present conditions (milk depots) would be a practical step in the right direction."

The difference of opinion between the BIHS and the Public Health Department became increasingly obvious in the early 1910s, when the municipal authorities were growing impatient at the slow progress they made in the central wards. In 1914, the MOH stated that while instructing "mothers of the intelligent class of artisans" was comparatively easy, working among the careless was "one of the most depressing of occupations." The BIHS never openly challenged the authorities, but it clearly distanced itself from the harder line they took. By keeping the question of poverty high on their agenda year after year, the society implicitly criticized the municipal authorities for basing their campaign on a narrowly focused definition of the problem. For example, studies made by the BIHS in the years 1914-16 strongly suggested that the family income had a greater effect on the development and growth of the infant than the cleanliness of the home or mother's willingness to carry out instructions.

A number of explanations can be offered for the differences in the approaches chosen by the BIHS and the Health Committee. An important and obvious one is the influence which middle-class women exerted on the design of the BIHS's programme. No matter how patronizing "philanthropic ladies" were towards working-class women, they were clearly more aware of many practical problems faced by poor mothers than the MOH and exclusively male Health Committee. Furthermore, the differences can be partly explained by the fact that the resources available to the BIHS were very limited. No one expected a voluntary society with a budget of £200 a year to solve the problem of poverty, and so medical doctors working for the BIHS were able to address this contentious issue in both their research work and in society's annual reports. The Birmingham Corporation, on the other hand, had resources to alleviate poverty in various ways, but the majority of decision-makers were ready to deal with this issue only if it was defined as a behavioural problem and not as a structural problem. Hence in constructing the infant welfare campaign, municipal health officials were under intense pressure not to create expectations that the municipality would take redistributive measures to improve the situation of the poorest mothers and children. This meant that health officials had to ascribe deprivation, which seemed to be responsible for the high rates of infant mortality, to ignorance and carelessness or, alternatively, to steer the discussion towards those causes of infant mortality which could be dealt with without confronting the question of poverty. If the health officials took any other path, they inevitably clashed with the decision-makers in the Health Committee and City Council.

Looked at from another perspective, the differences in the approaches reflected the different levels on which these agencies operated. While the BIHS aimed to reduce infant mortality in St. Bartholomew's Ward by

32 BIHS, Report for 1908, 15; for 1909, 10; for 1918-19, 11.

33 Annual Report for 1914, 17.

34 BIHS, Reports for 1908-1917.
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helping individual mothers to cope with their immediate problems, the MOH and Health Committee represented themselves as 'community watchdogs' who spoke for the welfare of entire society. These attitudes clashed in the discussion which concerned the provision of meals for pregnant and nursing mothers. The BIHS pointed out that providing the poorest mothers with meals would reduce infant mortality, whereas the Health Committee and MOH were wrestling with harmful effects this measure would potentially have on the moral welfare of the family. They warned that by offering meals to poor mothers, the municipality and voluntary societies could irretrievably damage male work incentives. In the case of infant milk depots, the difference of opinion was much the same. The BIHS argued that sterilized milk would protect bottle-fed babies from diarrhoea, while the Health Committee saw milk depots as a possible threat to the family and to the health of babies. Milk depots, the authorities contended, would sanction bottle-feeding and therefore encourage women to wean their babies early and to work in factories.33

Success and failure

Middle-class women's reform activities and the municipal infant welfare campaign reinforced and transformed each other in a significant way, particularly in the 1910s. The influence which societies such as the BIHS had on the municipal campaign manifested itself as specific plans and concrete measures in the years 1914-20, when the Birmingham Health Committee was reappraising the needs of mothers and children. This rethink was largely motivated by the start of the First World War which heightened anxiety over high infant mortality rates and prompted central government to make grants available to local authorities for the support of infant welfare work.

Encouraged by the central government backing, the Birmingham Health Committee decided to establish a number of new infant welfare centres and to extend services provided in these centres by introducing medical consultations for pre-school children and ante-natal consultations for pregnant women. Both these services had been pioneered in one form or another by the BIHS. In 1916, the Health Committee decided to provide subsidized meals for the poorest mothers in a municipal infant welfare centre, although both the MOH and Committee were still wavering over the issue. In their opinion, meals should not be made widely available but in some cases direct economic assistance to mothers in the form of meals would be justifiable on the grounds that it enabled mothers to breast-feed their babies for nine months. The BIHS had tried to put this point across for years.36 Furthermore, municipal authorities made a small number of hospital beds available to difficult cases of pregnancy and to seriously ill babies by making subscriptions to voluntary hospitals. The Boards of these voluntary hospitals, and in particular women members of the Boards, had

35 BIHS, Reports for 1908-1922. For health authorities' views, see Chapter 4.

36 For consultations, see 'Report of the MOH on maternity and child welfare during 1916'; BIHS, Report for 1910, 15, 18-9; for 1911, 20-5; for 1914-15, 20; for 1915-16, 15. For meals, see Annual Report for 1914, 20-1; BPRO, M&CWSC, minutes 7. 1. 1916 items 19-20; 4. 2. 1916 item 36; 3. 3. 1916 item 62; 2. 3. 1917 item 236; 4. 5. 1917 items 281-2; 5. 10. 1921 item 992 and document 2.
worked determinedly to introduce the services in the early years of the twentieth century.\textsuperscript{37} The fact that the municipal authorities in Birmingham and in many other British cities took these measures only when they were recommended by the Local Government Board has served to render middle-class women's initiatives invisible. Yet these new ways of defining the problem and responding to it were by and large initiated by voluntary societies in which middle-class women played an important role.

Another important criterion according to which the success of voluntary lady workers can be tested is their own 'career' in policy-making. Did the expertise these women acquired in voluntary work help them gain access to new positions of power within the official municipal government? In Birmingham, the answer was no in most cases. One member of the BIHS, Mrs Rosa Walker, who was involved in establishing the society in 1908 and a generous subscriber in the following years, was appointed as a co-opted member of the municipal Maternity and Child Welfare Sub-Committee, when it was established in 1915.\textsuperscript{38} In general, however, voluntary societies such as the BIHS which worked exclusively among mothers and young children cannot be described as stepping stones to municipal Committees. One reason why these voluntary efforts did not open up new possibilities for women may have been that many of these women did not determinedly seek more direct access to power within municipal policy-making. On the other hand, it is also obvious that their special skills and expertise were not highly valued by the official political system. By looking at the interests and affiliations of the nine women who managed to get places on the Birmingham Public Health Committee or on the Maternity and Child Welfare Committee during the period 1918-39, two main paths to these Committees may be discerned, and the infant welfare movement was not one of them. For middle-class women who aspired to a political career in these Committees, the best training grounds appeared to be the Boards of Guardians, other official bodies like the National Health Insurance Committees, or voluntary societies which did not confine themselves to improving the welfare of women and children but dealt with wider social problems such as poverty and housing. The working-class women who were appointed had usually acquired political expertise in trade unions, in the co-operative movement or in the Labour party.\textsuperscript{39}

Thus the sense of accomplishment that the voluntary workers felt as they saw the local government taking up their initiatives was soon replaced by a feeling of disappointment. Paradoxically, the decision of the City Council to commit itself to defraying 80 per cent of voluntary infant welfare centres' expenses marked the turning point. For many voluntary centres this was the beginning of the end. The decision, taken in 1919, meant that the municipal authorities together with the Ministry of Health shaped the course and goals of the

\textsuperscript{37} BPRO, Maternity and Child Welfare Committee (M&CWC), minutes 23. 4. 1920 item 580; Jones, History of the Hospitals, 57-8, 86-92.

\textsuperscript{38} BPRO, M&CWSC, minutes 12. 11. 1915 item 1; BIHS, Reports for 1908-17. The Maternity and Child Welfare Committee was established in 1917. Rosa Walker was a co-opted member of the Committee from 1917 to 1923.

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infant welfare campaign, and middle-class women who still ran voluntary centres were pushed farther and farther from the centre of decision-making. The municipal authorities still expected them to raise money to cover 20 per cent of the expenses incurred by running the centres, but not to launch new strategies. The content of services was now determined by appointed and elected officials, men and women, who had either professional qualifications or 'wider' political expertise, not by middle-class women who had focused their claims to develop infant welfare programmes exclusively on traditional female sphere of competence.40

Furthermore, the policies were increasingly implemented by professionals. The Birmingham Public Health Department had employed trained nurses and medical doctors in the 1910s, but the trend became more noticeable in the 1920s. From 1921, the Birmingham maternity and child welfare campaign was supervised by Dr. Ethel Cassie, who made study tours to the United States and Europe to develop services provided in Birmingham and who also participated in policy-making at the national level as a member of the Departmental Committee on Maternal Mortality.41 Under her supervision, infant welfare policies were being carried out by a growing number of medical doctors and trained nurses. Voluntary lady workers who had a long experience in infant welfare work but no qualifications were left to organize cookery classes and sewing clubs. In finding themselves on the margins of the infant welfare movement, many of them lost their interest in the campaign. One after another, voluntary societies informed the Health Committee that they were unable to continue running centres because of difficulty in raising money and in finding voluntary workers. During the period 1916-1926, the number of voluntary centres in Birmingham declined from seven to one, while the number of municipal centres grew from eight to twenty-one.42

EXPERTS AND INFANT WELFARE: GOTHENBURG 1900-20

In nineteenth-century Gothenburg, Sällskapet för uppmuntran av öm och sedlig modersvärd (The Society for Encouraging Tender and Moral Motherly Care) was the most important of the voluntary societies which aimed to 'protect' motherhood among the poorest section of the population. This society offered either casual work such as sewing, knitting and weaving or direct economic assistance in the form of cash and

40 BPRO, M&CWSC, minutes 7. 2. 1919 item 563; Ministry of Health, Maternity and Child Welfare: Circulars and Memoranda No 12, 1919 (HMSO, London 1919). For further discussion about how women's success at attracting public attention to reforms which they had initiated often diminished their control over these reforms, see Seth Koven, 'Borderlands: women, voluntary action, and child welfare in Britain, 1840 to 1914', in Koven and Michel (eds), Mothers of a New World, 94-135.


42 'Report of the MOH on maternity and child welfare during 1916', 13-4; Annual Report for 1925, 92-4; BPRO, M&CWC, minutes 10. 12. 1920 item 691; 11. 3. 1921 items 720 and 725; M&CWSC, minutes 2. 3. 1921 item 886; 29. 6. 1921 item 985; 24. 3. 1926 item 1819. See also, Florence Woodcock, 'The voluntary worker in our welfare centre', City of Birmingham Maternity and Child Welfare Magazine (1934) June, 18.
clothes to widows and married women who had difficulty maintaining their children. By setting strict conditions for assistance, the society sought to ensure that they would not only alleviate poverty but also instil a sense of moral responsibility in working-class mothers. Poverty alone did not qualify anyone for assistance; each applicant had to also convince the ladies that she was a caring mother. In laying down guidelines on how to distinguish the deserving mothers from the undeserving ones, the society placed very little emphasis on the methods of infant and child care. What really mattered was mothers' moral characteristics. All unmarried mothers and mothers who sent their children to beg were without exception deemed unworthy of voluntary help, irrespective of whether they took good care of their children or not.

The gospel of "cleanliness, godliness, and needlework" which the Sällskapet för sedlig modersvård brought to working-class homes had some important parallels with the early twentieth-century infant welfare campaign. For example, both encouraged self-help among poor working-class mothers by helping them to combine paid work with being a mother. However, there was no direct line of continuity between the two campaigns and it is evident that the Gothenburg infant welfare campaign borrowed more ideas from abroad than from old, local societies. None of the ladies who sat on the executive committee of the Sällskapet för sedlig modersvård in the late nineteenth or early twentieth centuries were active in the infant welfare campaign.

While the old networks of philanthropic activity failed to become an innovative force in the Gothenburg infant welfare campaign, new voluntary societies, established in the early years of the twentieth century, exerted a powerful influence in designing programmes to address the needs of infants and mothers. As discussed in Chapter 4, voluntary societies which ran milk depots, infant welfare centres and nurseries played a key role in the Gothenburg infant welfare movement until the 1940s. What distinguished these voluntary organizations from, for example, the Birmingham Infants' Health Society was the influential position of experts. While in Birmingham "philanthropic ladies" were active in developing infant welfare schemes alongside medical doctors until 1918, in Gothenburg experts hold a strong position in many organizations from the very beginning and voluntary lady activists had very little say in programmes. Yet to conclude that philanthropic ladies had a marginal role is not to say that women were completely isolated

43 Göteborgs universitetsbibliotek (GUB), KVINNOHistorisk arkiv (KA), Sällskapet för uppmuntran af om och sedlig modersvård, Handlingar 1877-1965: Stadgar för Sällskapet (Göteborg 1877); Några anteckningar om Sällskapet för uppmuntran af om och sedlig modersvård (Göteborg 1914); 80-års berättelse, 1849-1929 (Göteborg 1930). For philanthropic associations in Gothenburg, see Birgitta Jordansson, 'Hur filantropen blir en kvinna: fattigvård och valgbrenhet under 1800-talet', Historisk Tidskrift (1992), 468-87; Ulla Håglund, 'Kvinnorna och vålgörenheten', in Lili Kaelas and Kristina Soderpalm (eds), For hundra år sedan - skildringar från Göteborgs 1880-tal (Göteborg 1984), 199-208. See also, Frank K. Prochaska, Women and Philanthropy in Nineteenth-Century England (Oxford 1980), chapters 4 and 5 (the quote is from page 145).

44 GUB, KA, Sällskapet för uppmuntran af om och sedlig modersvård, Handlingar 1877-1965: Några anteckningar om Sällskapet, 80-års berättelse. The members of Sällskapet för sedlig modersvård did not belong to any municipal Committee or voluntary society (such as Föreningen Mjölkdroppen or Barnavärv) which were providing infant welfare services.

45 See also, Inga-Lisa Lundén, 'Från mjölkdroppen till barnavårdcentral - historik och utveckling', Tidsskrift för Sveriges sjuksköterskor 37 (1970), 198-201.
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from policy-making. Women were able to shape the infant welfare campaign in Gothenburg but mainly as professionals or semi-professionals not as voluntary activists.

*Integrated in the mainstream politics*

The voluntary society that was to have the strongest influence on the infant welfare campaign in Gothenburg was *Föreningen Mjölkdroppen* (FMD) which ran milk depots. An important reason why this society became so well entrenched in the Gothenburg infant welfare movement was that its executive committee shared an important characteristic with the municipal Health Committee. In both these agencies medical doctors had succeeded wielding most power. According to the rules of the society, at least two of the eight members of the executive committee were to be medical doctors, but it was standard practice that doctors had half of the seats. What further consolidated the power of the medical profession in the society was that the chairperson was usually a medical doctor who held a strong position in the local medical community. For example, during the first five years, 1903-08, the society was led by the First City Physician, Dr Karl Gezelius. Compared with the exclusively male Health Committee, the society was active in integrating women into policy-making, and the women who were appointed as members of the executive committee such as Dr. Gärda Lidforss-af Geijerstam and foster care inspector Hilda Enander had strong opinions about how infant welfare services should be developed. Yet the dominant position of men in this society was not under threat. From the early years of the twentieth century to the 1940s, the majority of the members of the executive committee were men, and most medical doctors who worked for the milk depots in the early twentieth century and for the infant welfare centres in the 1920s and 1930s were also men.46

Unsurprisingly, the FMD which had close links with the medical and municipal establishments in Gothenburg did not challenge the health authorities' views. Both the Gothenburg health authorities and the FMD defined infant mortality, to a large extent, as a medical problem. Although both these agencies often pointed out that many mothers were ignorant of the safe methods of infant care, they did not launch a large scale campaign to educate "ignorant and careless" working-class mothers as the Birmingham authorities did. Similarly, they acknowledged that poverty was an important contributory factor to the high rates of infant mortality, but they did not examine in detail the possible connection between infant deaths and the malnutrition of mothers as the Birmingham voluntary societies did. Both the Gothenburg authorities and the FMD preferred to concentrate on medical aspects of maternal and infant welfare. The division of responsibilities between these two agencies was that the municipal authorities ran hospitals and subsidized midwifery care which was provided outside institutions. The FMD focused on 'problem babies' who could

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not be raised solely on breast milk.47 A mother's inability to breast-feed was often defined as a medical condition and the consequences of this condition were alleviated by providing free sterilized milk for the baby.48 As a result of the growing interest in infant welfare among decision-makers, the Gothenburg City Council started funding the FMD in 1910.

In addition to the FMD, voluntary societies which ran nurseries received financial support from the municipal authorities.49 The executive committees of these societies usually consisted of women, both professionals and "philanthropic ladies."50 Many of these women distanced themselves from the official thinking which emphasized the medical aspects of infant welfare. They saw infant mortality as a social problem caused partly by irresponsible fathers who did not support their illegitimate children and partly by irresponsible (male) decision-makers who did not protect unmarried mothers or poor mothers in general.51 In 1906 and 1907, at the instigation of foster care inspector Hilda Enander, two nurseries were opened for infants whose mothers were either ill or working outside the home. A third nursery for infants was established in 1910.52

Women reform activists and infant welfare

It seems that in early twentieth-century Gothenburg middle-class women were able to influence the infant welfare programmes only if they were integrated into the mainstream health politics. The women who had a say in programmes were medical doctors, foster care inspectors and nurses who had managed to carve a niche for themselves in both municipal and voluntary health care systems. More often than not, these women worked under the direction of men or with male colleagues and were answerable to male-dominated municipal or voluntary committees. In many cases, they succeeded in pushing through proposals only if they were able to link their concerns to the political and economic questions which male decision-makers placed high on their agenda. Hence it is difficult to analyze the role which these women played in the policy-making process. In order to shed light on the ways in which they, individually and through organizations, exerted an

47 See Chapter 4 and Marjaana Niemi, 'For the common good? Women and public health in Birmingham and Gothenburg 1900-1939', in Gullikstad and Heitmann (eds), Kjønn, makt, samfunn i Norden, 111-29; GHS 1911:27.

48 The Gothenburg health authorities and the FMD argued that some mothers were unwilling to breast-feed their babies, but they paid less attention to these 'careless' mothers than did their counterparts in Birmingham. GSH 1911:27, in particular 8-9. See also, Gena Weiner, 'De "olydiga" mödrarna. Konflikter om spädbensvård på en Mjölkdroppe', Historisk Tidskrift (1992), 488-501.

49 GSH 1909:252 and minutes 7. 1. 1910 item 6; 1911:27 and minutes 16. 2. 1911 item 26; 1911:264 and minutes 30.11. 1911.

50 See, for example, Föreningen Bamavärm, GSH 1909:6.

51 Frigga Carlberg, 'Frivilligt arbete för spåda barn i Göteborg', Social Tidskrift (1908), 537-8.

52 GSH 1909:252 and minutes 7. 1. 1910 item 6; Carlberg, 'Frivilligt arbete'.

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influence on the infant welfare campaign in Gothenburg, this last section looks briefly at the reform activities of two women, Dr Gärda Lidforss-af Geijerstam and Hilda Enander. They both were involved in the FMD, in voluntary societies which ran nurseries and in many other municipal and voluntary agencies, initiating important reforms and challenging official thinking about health problems.

The discussion about nursery provision and unmarried mothers in the early twentieth century reveals clearly that policy-makers campaigned for nurseries for widely different reasons. About 20 per cent of new-born babies in Gothenburg were illegitimate, and in consequence a significant proportion of women who had children were solely responsible for them. Municipal authorities went to great pains to emphasize that it was the duty of single mothers either to place their children in a good foster home or to keep the children and to combine paid work with motherhood. Irrespective of which path single mothers decided to take, they usually encountered difficulties. Against this background it is easy to understand why the City Council assisted voluntary nurseries. Nurseries "provided mothers with opportunity to earn money" and therefore kept them and their children off public funds. However, when the municipal foster care inspector Hilda Enander in 1906 suggested that one of the voluntary societies in Gothenburg should establish a nursery for infants, the finances of the Gothenburg Corporation were not uppermost in her mind. Both her work in voluntary societies and as a municipal foster care inspector had convinced her that early twentieth-century Swedish society had forgotten the interests of children and women. In her opinion, society would be improved only if motherhood was more highly valued and if children were looked after by their own mothers. Thus she campaigned for nursery provision not to restrict the burden imposed on the ratepayers but to help unmarried mothers keep their children.

The policies of the FMD provide another good example of how women linked their concerns to wider issues. During the first decade of the twentieth century, this society had largely confined its activities to providing milk for babies who were not breast-fed and to examining these babies once a fortnight. In the 1910s, the milk depots were still the main activity, but increasing importance was also attached to health education. Mothers were instructed in infant care and nutrition in the clinics and in their own homes. Dr. Gärda Lidforss-af Geijerstam favoured the new emphasis, even though she thought that the education provided by the FMD and other voluntary societies was not wide-ranging enough. While the FMD advised mothers in order to reduce infant mortality, Lidforss-af Geijerstam regarded education also as a way of improving the health and welfare of women. Throughout her career Lidforss-af Geijerstam devoted much time and effort to instructing girls and women not only in infant care, but also in other questions of health and hygiene and in birth control. For example, she, together with the Social Democratic women's group, established the first

53 Statistisk årsbok för Göteborg, för 1900-1939.
54 GSH 1909:252 and minutes 7.1.1910 item 6; 1926:192 and minutes 12.5.1926 item 24.
55 See, for example, GSH 1917:284, 2-4.
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birth control clinic in Gothenburg in 1924. At the instigation of Nathalia Ahlström, a member of the Health Committee, this clinic was taken over by the municipality in 1930.

CONCLUSION

The case study of Gothenburg and Birmingham confirms, to an extent, Koven and Michel's argument about the role of women in maternal and infant welfare movement. In both these towns, health and social welfare programmes were influenced by female activists and their initiatives, commitments and visions. Moreover, in Birmingham where political and social arrangements were relatively fragmented, voluntary lady activists were vocal and they had space for developing welfare schemes, at least until 1918. In Gothenburg, the centralized structure of decision-making made it much more difficult for "philanthropic ladies" to establish a foothold in the policy-making process. Hence in order to understand the role which middle-class women played in shaping infant welfare policies in Gothenburg, one has to look at both the voluntary and public sectors. In Gothenburg, where much emphasis was placed on expertise knowledge, female medical doctors, health inspectors and other experts who managed to integrate themselves into mainstream politics were far more influential than voluntary lady activists.

WORKING-CLASS WOMEN AND WELFARE PROVISION

In her study on the feminization of poverty in the United States, Diana Pearce argues that antipoverty programmes have failed to tackle female poverty, since "poor women are subjected to programs designed for poor men." A similar kind of bias against women seems to have permeated most health care and welfare


57 Göteborgs stadsarkiv (hereafter GSA), Hälsovårdsnämnden II avdelningen (hereafter HVN II), minutes 5. 1. 1928 item 16; 10. 10. 1930 item 446.

58 Diana Pearce, 'Welfare is not for women: why the war on poverty cannot conquer the feminization of poverty', in Linda Gordon (ed.), Women, the State, and Welfare (Madison 1990), 265-79. For Northern Europe see, Pat Thane, 'Women and the Poor Law in Victorian and Edwardian England', History Workshop, issue 6 (1978), 29-51; Jan Gröndahl, 'Single mothers and poor relief in a Swedish industrial town (Gävle) at the beginning of the twentieth century', in Marie C. Nelson and John Rogers (eds), Mother, Father, and Child: Swedish Social Policy in the Early Twentieth Century (Uppsala 1990), 31-53; Volker Hunecke, 'Überlegungen zur Geschichte der Armut im vorindustriellen Europa', Geschichte und Gesellschaft 9 (1983), 482-512. For further discussion about the bias against women in late-twentieth-century social policies, see for example, Gisela Bock and Pat Thane, 'Editors' introduction', in Bock and Thane (eds), Maternity and Gender Policies, 1-20; Helga Maria Herses, 'Women and the welfare state: the transition from private to public dependence', in Anne Showstack Sasson (ed.), Women and the State: The Shifting Boundaries of Public and Private (London 1987), 72-92; idem, Welfare State and Woman Power: Essays in State Feminism (Oslo 1987); Lewis, Women in Britain since 1945, 103-4.
systems in Europe and the United States. Firstly, leaving aside the matters of reproductive health, female illness has attracted much less scientific attention than male illness throughout the twentieth century. In consequence, medical doctors have routinely provided women with medical therapies which have been designed specifically for male bodies. Secondly, female illness and poverty has rarely been high on public health authorities' agenda. The assumption that cause-of-death tables were also a relatively good indicator of morbidity was one factor which served to conceal the prevalence of ill-health among women in the early twentieth century. It directed health authorities' attention away from debilitating, but not fatal, illnesses such as anaemia, headaches, gynaecological disorders and rheumatism which were common among working-class women. Thirdly, the principal concern of early twentieth-century health insurance systems was to provide (male) workers with sickness benefits and some medical treatment. Ill-health (and poverty) of contributors' dependants were almost completely ignored, and even women who worked in the insured occupations and therefore were covered by insurance schemes were often discriminated against. For example, in Britain, health insurance benefits of married women workers were cut in 1932 because of the large number of claims they made. Unsurprisingly, the same principle was not applied to the benefits of other groups with 'excessive' claims such as miners.

Since female illness and poverty were rarely regarded as public concerns, it was usually left to women's organizations such as the Women's Co-operative Guild and Women's Labour League in Britain and Social Democratic women's groups in Sweden to discuss and investigate these questions. In Britain, for example, a collection of 'maternity letters' compiled by the Women's Co-operative Guild in 1915 and a survey conducted by the Women's Health Enquiry Committee in 1939 revealed a range of health and social problems about which the reports of the Medical Officers of Health were noticeably silent. From these surveys and discussions came the call for official attention to female ill-health and poverty and to political representation for the interests of women. Yet these calls were usually ignored not only by local and central governments but also by mixed-sex working-class organizations. Ann-Sofie Ohlander and Linda Gordon, who have


60 Spree, Soziale Ungleichheit, 19-49. See also, Annual Reports for 1900-1939; Göteborgs Hälsovårdsnämnds Årsberättelser (hereafter Årsberättelse) för 1900-1939.


studied the Swedish Social Democratic Party and the British Co-operative Movement respectively, argue that the organizations engaged in male-oriented politics and were not particularly receptive to women's proposals. Pat Thane, though taking a more optimistic view, concludes that women "could make only a limited impact on a male-dominated (Labour) Party, and very little where their proposals conflicted with the political, ideological or material interest of powerful sections of the party."

In the short-term, working-class women's only chance of achieving their aims seemed to be to ally themselves with more influential groups and to link their own demands to campaigns such as the infant welfare campaign which had wide currency in society. This section examines the extent to which working-class women accepted health authorities' views either with conviction or calculation and the extent to which they challenged them. By drawing on material produced by the municipal authorities and working-class organizations in Birmingham and Gothenburg and on secondary literature on working-class women's organizations in Sweden and Britain, the next section looks briefly at the strategies working-class women used and alliances they forged with middle-class women, working-class men and public health officials to advance the levels of social-welfare provision.

MOTHERS AND WORKERS: WORKING-CLASS WOMEN IN GOTHENBURG

Questions concerning women and children's welfare figured prominently at the Social Democratic women's national conference in Stockholm in 1908. The Stockholm group, drawing the conference participants' attention to the widespread discontent over the legal inequality between husband and wife, suggested that the conference should make a public statement about the question. The Gothenburg group pointed out that the legislation concerning children's employment in factories and workshops was not fully implemented in many towns. Other groups called for improved health and social services such as maternity insurance and advice on infant care which together would enable mothers to take better care of themselves and their young children, higher wages for women, municipal nurseries situated near factories, improvements in the legal and social status of unmarried mothers and their children, sex education, beginning in youth, and access to birth


65 'Kvinnokongressen i Stockholm', *Ny Tid* 8. 8. 1908. See also, 'Kampen om barnen: skola eller fabriksarbete', *Ny Tid* 5. 3. 1900.
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control. Furthermore, several groups demanded the vote for women, and they wanted to see more women involved in municipal decision-making and in the administration of new health care and social services.66

Some motions which were put forward at this conference can be read as working-class women's contributions to the more general debate on the "social question" that preoccupied Swedish social and health politics in the early twentieth century.67 The motions and resolutions concerning the rights and responsibilities of unmarried mothers clearly fell to this category. As discussed in the chapter 4, the strategy which the Gothenburg authorities used to improve the 'welfare' of unmarried mothers and their children was two-fold: unmarried mothers were offered help and support but they were also subjected to close supervision. The Social Democratic women criticized the reform activities for being based on the assumption that single mothers were morally culpable for their poverty. They pointed out that the municipal authorities would achieve little if they confined themselves to disciplining and reforming unmarried mothers, since men, government and the capitalist economy were largely responsible for the hardships which unmarried mothers and children suffered.68 Had working-class women provided the only critique of the system which left unmarried mothers unable to maintain themselves and their children, policy-makers might have ignored the question, but in the early twentieth century there were many other groups which demanded that more attention should be paid to the problem. The Social Democratic women were well aware that in order to alleviate the problems of unmarried mothers and poor mothers in general, they had to forge alliances with these more powerful groups. However, joining forces with other groups was not unproblematic, since the Social Democratic women disagreed with them about many basic questions.

In Gothenburg, where the labour market was thoroughly sex-segregated, male workers did not particularly fear women's competition for jobs. Hence the Social Democratic Party and trade unions were usually ready to support the claims which women made for higher wages and improved working conditions. What the Social Democratic Party did not support was the women's campaign to improve the legal and economic position of unmarried mothers. In this question, women clearly challenged the official party line. The Social Democratic women's groups of Malmö and Norrköping adopted the most strident posture, applying the rhetoric of the class struggle to the gender conflict.69 The leading members of the Malmö group


67 Ohrlander, I barnens och nationens intresse.

68 'Kvinnokongressen i Stockholm', Ny Tid 7. and 8. 8. 1908

69 Norrköping was a textile town where a large proportion of both unmarried and married women worked full-time outside the home. See, for example, Carl Lindman, Dödligheten i första lefnadsåret i Sveriges tjugo större städer 1876-95 (Stockholm 1898), 89-92.
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compared non-supporting fathers to strike-breakers, and the Norrköping group attacked them as traitors. Other Social Democratic women's groups, including those of Gothenburg and Stockholm, disassociated themselves from the rhetoric of class struggle which the Norrköping and Malmö group used. Yet they, together with the Norrköping and Malmö groups, called for reforms which would help unmarried mothers gain legal recognition of the paternity and economic assistance from the fathers. In this question, the views of the Social Democratic women converged with those of the municipal authorities who sought to compel men to support their illegitimate children. In planning the reforms to 'protect' unmarried mothers and their children, the municipal authorities did not consult working-class women, and working-class women were at best ambivalent as to their expectations of public health policies. However, the fact that working-class women denounced non-supporting fathers in no uncertain terms made it easier for the authorities to put pressure on fathers.

Although working-class women warmly welcomed some of the reforms which the municipal authorities introduced in Gothenburg and other towns, they criticized the authorities for urging unmarried mothers to give their children away. The Social Democratic women's groups were of the opinion that mothers should have a choice and that society should help mothers irrespective of whether they decided to keep their children or give them away. In this issue, support came from two quarters, from social reformers such as Dr. Isak Jundell who strongly criticized the line which most municipal authorities had taken and from middle-class women. These groups argued that women should be encouraged to raise their children themselves partly because breast-fed babies had a better chance of survival and partly because the strengthening of the mother-child bond would further the moral progress of society. In order to provide practical help for unmarried women who wanted to keep their children, middle-class women established nurseries. What caused friction between the Social Democratic women and social reformers was that many of the reformers castigated unmarried mothers for their 'immorality' and did not give explicit consideration to their needs. The Social Democratic women demanded that society should be more tolerant of different types of families.

Health education, sex education and birth control advice were topics which united the Social Democratic women's groups and female medical doctors. At the Social Democratic women's conference in 1908, the


71 GSH 1912:18; 1912:273.


73 Carlberg, 'Frivilligt arbete'; Jundell, 'Moderskydd'.

74 GSH 1911:27, 8; Jundell, 'Moderskydd'; 'Kvinnokongressen i Stockholm', Ny Tid 7. and 8. 8. 1908. For the growing importance of motherhood, see Torborg Lundell, 'Ellen Key and Swedish feminist views on motherhood', Scandinavian Studies 56 (1984), 351-69; Cheri Register, 'Motherhood at center: Ellen Key's social vision', Women Studies International Forum 5 (1982), 599-610.
Norrköping group vehemently argued that the health authorities' negative stance on birth control was a vehicle for oppressing working-class people and in particular working-class women. The Gothenburg and Stockholm groups took, again, a less militant stance. However, the Social Democratic newspaper in Gothenburg took a relatively positive view on birth control and in particular on sex education from an early date, and in the 1920s the local Social Democratic women's group, with Dr. Gärda Lidforss-af Geijerstam, established the first birth control clinic in the city.

**HEALTHY MOTHERS AND HEALTHY CHILDREN: WORKING-CLASS WOMEN IN BIRMINGHAM**

In Birmingham and in Britain in general, the main protagonist of the welfare rights of working-class women was the Women's Co-operative Guild; an association consisting mainly of married women from the upper strata of the working class. The Guild, as the Social Democratic women's groups in Sweden, campaigned for a greater marital equality and improved welfare provisions and called for a wider role for women in local and national policy-making. However, there were also important differences between the British and Swedish organizations in the early twentieth century. While the Social Democratic women's groups in Sweden discussed the problems of unmarried mothers and called on the municipal authorities to provide nurseries and sex education, the Guild gave especial attention to maternity care; a policy area which the British public health authorities had relegated down on the priority list.

In 1906, after a group of Guild members had acquainted themselves with maternal and infant welfare campaigns which Belgian "co-operative and socialist societies" had launched, the organization appealed for the British public health authorities to provide similar kind of services. In 1914, the Guild outlined a more comprehensive proposal concerning maternal and infant welfare and sent a deputation to the Local Government Board (LGB) to press the implementation of their proposal. The LGB, which was under pressure from public health officials and social reformers to take firm action to improve infant welfare, recommended local health authorities to adopt most of the Guild's programme. In the proposal, the Guild had paid much attention to a problem which had concerned many women's organizations in Birmingham: a

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75 'Kvinnokongressen i Stockholm', *Ny Tid* 7. 8. 1908.


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low standard of midwifery. As early as 1904, the Birmingham Health Committee had received a deputation from the Birmingham Union of Women Workers which had urged the Committee to provide additional facilities for midwifery training. However, the Committee had been rather reluctant to spend money on the purpose and had confined itself to appointing a midwife inspector and to making subscriptions to voluntary hospitals which organized courses for midwives. In the 1920s, the Guild and other women's organizations increasingly emphasized the importance of adequate hospital accommodation. The Guild appealed for the public health authorities to provide maternity beds, for example, for mothers whose living conditions were poor. Furthermore, in 1928, the Duddeston Branch of the Guild in Birmingham pointed out that "there is a great need of more rest homes for all mothers who need quiet and rest for a time before confinement."

The poor health of many working-class mothers was an important reason why the Birmingham Women's Co-operative Guild, representing 31 branches with a membership of 1,860, urged the municipal authorities to establish a birth control clinic in the city in 1930. Similar kind of requests were also made by the Birmingham Women's Welfare Centre and the Women's Advisory Council of the Birmingham Labour Party. These requests, though attracting strong support from female medical doctors, found little favour with the Health Committee and with the MOHs, Dr John Robertson and his successor Dr. H. P. Newsholme. They were of opinion that the public health authorities should not advise women on birth control, not even when a woman's life was in danger. However, in 1935, the Health Committee and the City Council finally bent on their attitude to birth control and decided to establish a municipal clinic, where advice was given to married women who were suffering, for example, from tuberculosis or heart disease.

The municipalization of the voluntary maternity and infant welfare services in the 1920s was welcomed by many working-class clients. Despite the fact that working-class women truly appreciated services such as subsidized or free meals which "philanthropic ladies" had initiated, they seemed to prefer municipal services. An important reason for this was that the municipality could provide maternal and infant welfare services as rights, whereas the voluntary sector inevitably provided them as charity. Another reason could have been that working-class women found the attitude of paid, trained health visitors less patronizing than that of

79 Gaffin and Thoms, *Caring and Sharing*, 71-3; Llewelyn Davies, *Maternity*, Appendix: 'National scheme proposed by the Women's Co-operative Guild'.

80 BPRO, HC, minutes 14. 6. 1904 items 8710 and 8714; 13. 12. 1904 item 9025 & 9029; 15. 11. 1904 item 8953; 14. 2. 1905 item 9123; 11. 7. 1905 item 9411; 22. 12. 1911 item 78; 10. 1. 1913 item 1063.

81 BPRO, Women's Co-operative Guild (hereafter WCG), Duddeston Branch, minutes 5. 3. 1928.

82 BPRO, M&CWC, minutes 12. 12. 1930 item 464; M&CWSC, minutes 17. 12. 1930 item 350.

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voluntary lady workers. The minute books of the Duddeston Branch of the Birmingham Women's Co-operative Guild reflected the great appreciation of municipal services. The branch often invited experts and executives from the Birmingham Public Health Department and the City Council to give brief talks about municipal services, and it arranged for its members to visit municipal hospitals and other institutions.

In both Birmingham and Gothenburg, working-class women's organizations appealed for the municipal authorities to provide assistance for sick mothers in performing their domestic duties. In Gothenburg, women called on the authorities to establish nurseries, where children could stay while their mother was seriously ill. In Birmingham, in contrast, the local branches of the Women's Co-operative Guild urged the health authorities to provide home helps. This proposal, which was broadly in line with the wider aims of the Birmingham infant welfare campaign, met with the approval of both the Health Committee and the MOH. Working-class women's organizations and the MOH presented a united front also against the Housing Committee's plans to build tenement blocks to ease the housing shortage. The Soho Ward Women's Labour Party was against building flats but they also criticized plans to lower housing standards. The Balsall Heath Women's Co-operative Guild argued that flats were "dangerous to the health of our nation," and the Pineapple Women's Section stated that flats would be especially "detrimental to the health of our women and children."

CONCLUSION

In Gothenburg, working-class women accepted many central tenets of the official infant welfare campaign. For example, they accepted that, if need be, they had responsibility for working outside the home and providing for their children. What they expected of the municipal authorities was more services which would have helped them reconcile their productive and reproductive roles. Furthermore, they appealed for central and local governments to tackle women's inequality in the labour market and to secure that, for example, single mothers could earn enough to maintain their families. Similarly, working-class women in Birmingham generally accepted the terms of debate set by the public health authorities. Women's organizations, as the municipal authorities, assumed that most women would aspire to a primarily domestic role. However, women's organizations criticized the municipal authorities for concentrating almost

84 Thane, 'Visions of gender'; Marks, Metropolitan Maternity, 177-85, 257-8, 263-73. See also a letter from the WCG to Municipal Citizen Committees, in which the WCG urges municipalities to provide, for example, free dinners to expectant and nursing mothers and free milk for mothers and young children, BPRO, PH&HC, minutes 10. 9. 1914 item 2602.

85 BPRO, WCG Duddeston Branch, minutes 12. 7. 1926; 11. 7. 1927; 5. 9. 1927; 19. 3. 1928; 16. 7. 1928; 15. 10. 1928.

86 BPRO, WCG Duddeston Branch, minutes 5. 3. 1928.

87 BPRO, PHC, minutes 23. 1 1925 item 8825; 25. 2. 1925 item 8901. See also WCG, Duddeston Branch, minutes 12. 7. 1926.
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exclusively on safeguarding the health of children. They called on the municipal authorities to give explicit consideration to the needs of mothers as well. In particular, they urged the municipal authorities to improve mothers' access to medical care and to provide services which would help mothers perform their domestic duties. In both cities, working-class women's organizations managed to achieve some of their aims by allying themselves with middle-class women and in particular female medical doctors, with working-class men and with public health officials.

— WORKING CLASS AND TUBERCULOSIS —

Although tuberculosis was never the centre of attention in working-class politics, the question was often discussed in left-wing newspapers and pamphlets in the early years of the twentieth century. In Gothenburg, the Social Democratic newspaper, Ny Tid, gave its full support to the First City Physician, Dr. Karl Gezelius, who actively campaigned to increase public awareness of the disease and urged the City Council to provide hospital and sanatorium beds for tubercular patients. The newspaper argued vehemently that Sweden's campaign against tuberculosis lagged behind those of many other European countries and that the backwardness was due to the complacency among middle-class policy-makers not to financial stringency. In order to prove their point the writers juxtaposed the millions which were spent on armaments to defend Sweden against its outside enemies with the small amount of money available to fight "the most formidable enemy" within the country, tuberculosis.

To keep its readers up to date, Ny Tid followed the major developments in the international tuberculosis research and anti-tuberculosis work. In 1903, it wrote, for example, about the scientific controversy over the question of whether infection was possible through the consumption of meat and milk from tuberculous cattle. The paper also reported that German health insurance agencies and Danish voluntary organizations which in the preceding few years had made determined efforts to provide treatment for people suffering from tuberculosis were beginning to show results. In Sweden, at the same time, a large number of working-class

88 The question of what the public, and in particular the working class, thought about public health reforms has received little systematic attention. See, however, Michael Sigsworth and Michael Worboys, 'The public's view of public health in mid-Victorian Britain', Urban History 21 (1994), 237-50; Barnes, The Making of a Social Disease, 215-46. More research has been done on the patient's view of medicine, see for example, Roy Porter (ed.), Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society (Cambridge 1985); Roy Porter, 'The patient's view: doing medical history from below', Theory and Society 14 (1985), 175-98; Linda Bryder, Below the Magic Mountain: A Social History of Tuberculosis in Twentieth-Century Britain (Oxford 1988), 199-226; Deborah Lupton, Medicine as Culture: Illness, Disease and the Body in Western Societies (London 1995), 79-104.

89 'Kampen mot tuberkulosen: förslaget om sanatorium för Göteborg', Ny Tid 10. 9. 1903; 'Sanatorifrågan vinner gehör', Ny Tid 10. 9. 1903; 'Reneströmska fonden', Ny Tid 11. 9. 1903; 'Renströmska fonden', Ny Tid 12. 10. 1903; 'Stadsfullmäktige i går', Ny Tid 14. 12. 1903; 'Lungssoten. Den fattiges öde', Ny Tid 27. 7. 1908.

90 'Kampen mot tuberkulosen', Ny Tid 27. 8. 1903.
people who could have recovered died of tuberculosis, since they were not offered the treatment which was available to German and Danish workers. The paper wished that the Gothenburg City Council would, for once, be "both practical and humane and not to make the same excuses" that they always made when they were asked to take measures which benefited the poorest section of the population.91

City Council's decision to build a hospital for tubercular patients in 1903 met with a warm response, and most left-wing politicians and working-class organizations remained favourable to sanatorium and hospital treatment of tuberculosis even when it became evident that the therapies which were available did not come up to expectations. Working-class support for the municipal anti-tuberculosis scheme and other public health campaigns in the 1920s and 1930s was partly due to the fact that in Gothenburg the working-class parties, the Social Democrats and the Communists, predominated in the City Council and had a much greater say in how the municipal health policy was constructed than they had had in earlier decades. However, this alone does not explain the consensus of opinion.92 In Gothenburg, the working class, or at least the politicians who represented them, largely shared the public health experts' view that the provision of institutional treatment for early cases of tuberculosis and the isolation of advanced, infectious cases were in the best interests of the whole community. Widespread acceptance of the institutionalization of tubercular patients manifested itself, for example, in the motion which Councillors Ragnar Andersson and Einar Adamson, both Communists, put forward as late as 1930. They suggested that the Gothenburg Health Committee follow the example set by the Soviet health authorities and establish yet another institution, a night sanatorium, for tubercular patients who were able to work but required some regular treatment and care.93 Similarly, health education was widely approved in Gothenburg. Although only few tubercular patients could and did follow the doctors' orders to the letter, the advice given by doctors and tuberculosis inspectors was rarely called into question in public discussions.

In Birmingham, the municipal tuberculosis scheme did not attract similar popular support. While most socialist politicians and writers accepted that unhealthy habits played a role in causing the disease, they were rather sceptical about the educational health campaign which the health authorities launched. For example, in 1905, when the Birmingham Health Committee and the MOH set about investigating the possibility of

91 'Kampen mot tuberkulosen: förslaget om sanatorium för Göteborg', *Ny Tid* 4. 9. 1903; 'Kampen mot tuberkulosen. Diskussionen om kreaturstuberkulosen', *Ny Tid* 8. 9. 1903; 'Tuberkulosen', *Ny Tid* 12. 10. 1903.


93 GSH 1930:147; 1931:86 and minutes 19. 3. 1931 item 32. Night sanatoria played an important part in the Soviet anti-tuberculosis campaign. "While the treatment of tuberculosis does not basically differ from that used in other countries, the Soviet health authorities have decidedly different views concerning the social readjustment of tuberculous people. The principle is not to send the tuberculous worker "to the land" as is done elsewhere. It is believed that the patient can be supervised medically much more closely in factories than in agricultural enterprises." Henry E. Sigerist, *Socialised Medicine in the Soviet Union* (London 1937), 236-41. See also, GSH 1925:3 and discussion 15. 1. 1925 item 32, 10.
establishing a sanatorium where tubercular patients could rest and be reformed, left-wing politicians and working-class organizations showed little interest in the question. Friendly societies, however, were an exception. Sickness benefits which the Friendly societies paid to the members who were suffering from tuberculosis were a heavy drain on their resources and, in consequence, the societies were more than willing to share the burden with the municipal health authorities and rate-payers. Indeed, Councillor S. G. Middleton who was a member of the Ancient Order of Foresters, a friendly society which had traditionally opposed state welfare, was one of the most active campaigners for a municipal sanatorium in Birmingham.94

In general, the Birmingham case supports Michael Worboys's conclusion that in Britain there is little evidence of any demand for sanatorium treatment directly by potential working-class patients.95 The demand was largely created by local authorities, general practitioners and voluntary organizations. By the time the first sanatorium was opened in Birmingham in 1909, these agencies had managed to assure hundreds of tubercular patients that sanatorium treatment was their best hope for regaining health. In consequence, only a proportion of the people who sought the treatment in the years before the First World War could be admitted to sanatoria. However, the confidence which many patients might have had when they first entered to these institutions was soon ebbing. As discussed in the Chapter 5, a considerable proportion of patients, sometimes more than 20 per cent, left the sanatorium before the end of the recommended treatment period.

Environmental improvements

Although most left-wing politicians in Gothenburg agreed with the health authorities that the municipality should provide sanatorium and hospital treatment for tubercular patients, they criticized the authorities for concentrating exclusively on medical care. They pointed out that improvements in patients' health which sanatorium treatment brought about were usually short-lived, since the authorities did very little to help patients readjust to 'normal' life when they returned from the sanatorium.96 If the municipal anti-tuberculosis campaign was to succeed, medical services should be supplemented with measures which would alleviate poverty and improve people's living and working conditions. In particular, in the 1910s and 1920s, when the housing problem was extremely severe in Gothenburg, the health authorities were criticized for ignoring social and environmental factors which made people susceptible to tuberculosis and other diseases.

94 BPRO, HC, minutes 11. 4. 1905 item 9233; 11. 7. 1905 item 9395. See also, Thane, 'The working class'; idem, The Foundations of the Welfare State, 28-30.


96 'Lungsoten: den fattiges öde', Ny Tid 27. 7. 1908; 'Livet på sanatorierna behöver reformeras', Ny Tid 9. 5. 1910. Left-wing politicians also criticized living conditions in old sanatoria and hospitals. See, GSH 1923:328 and minutes and discussion 13. 9. 1923 item 16.
Instead of settling for half-measures, the health authorities should have ensured that tubercular patients had both medical care and healthy homes.\textsuperscript{97}

In Birmingham, Socialist politicians and writers often pointed out that an unhealthy way of life might well be an important contributory factor to tuberculosis but that unhealthy habits and behaviour, in turn, were largely due to defective housing. Poor living and working conditions, they argued, were exerting a demoralising effect on the tenants. These writers castigated the health authorities for taking refuge behind the educational campaign and not tackling the "real causes" of tuberculosis: defective housing and insanitary environment. As Councillor E. A. Wilson put it in 1913, the Public Health Committee had been "amazingly active in creation of sanatoria, etc., but have allowed the housing question to be shelved."\textsuperscript{98}

Left-wing critics were convinced that scientifically sophisticated arguments were the key to persuading the public or at least townspeople who were "concerned with the development and administration of local government." Thus the analyses which left-wing politicians and writers did of urban health problems often rested on claims to scientific truth. J. A. Fallows, one of the first Labour Councillors in Birmingham, often made use of material published by the Birmingham MOHs and by other public health experts in Britain and abroad, but he placed the facts in another context and looked at them from a different perspective. This does not mean that Fallows would have questioned the expertise of MOHs and their ability to analyze health problems; on the contrary, he clearly respected both Alfred Hill and John Robertson. On the other hand, Fallows levelled fierce criticism against John Nettlefold, the Chairman of the Housing Committee. Fallows argued that Nettlefold had set before the Housing Committee "the impossible task of harmonising private greed and public benefit" and that he had spent public money in the ways which "can only benefit private speculators, whether in form of compensation to property owners or of subsidies to builders."\textsuperscript{99}

\textit{Protecting the healthy}

In the early years of the twentieth century, increasing awareness of the infectious nature of tuberculosis fuelled public panic. In most cases, the fear and anxiety found its expression in the discrimination and personal abuse of the sick. People did not openly protest against the anti-tuberculosis campaign but contested its principles in their every-day life. In both Birmingham and Gothenburg, employers, landlords,

\textsuperscript{97} 'Kampen mot tuberkulosen'. \textit{Ny Tid} 27. 8. 1903; GSA, HVN I, minutes 1. 8. 1928 item 115 and document C; 2. 4. 1930 item 62 and document K.

\textsuperscript{98} J. A. Fallows, \textit{The Housing of the Poor: Pamphlets on Economic Questions issued by the Birmingham Socialist Centre No 1} (Birmingham 1899); J. A. Fallows and Fred Hughes, \textit{The Housing Question in Birmingham} (Birmingham 1904); C. E. Smith, \textit{Memorandum on the Housing Question submitted to the Housing Enquiry Committee of the Birmingham City Council on behalf of the Birmingham Socialist Centre, the Trades' Council and the Labour Representation Council} (Birmingham 1914).

\textsuperscript{99} Fallows and Hughes, \textit{The Housing Question}. For Dr. Alfred Hill, see Alan Mayne, \textit{The Imagined Slum: Newspaper Representation in Three Cities 1870-1914} (Leicester 1993), 80.
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shop owners, neighbours and relatives ignored the health authorities' recommendations by refusing to employ people who were suspected to suffer from the disease, by evicting them from their homes and by isolating them socially. Furthermore, the health authorities were often criticized, explicitly or implicitly, that they endangered the health of the community by allowing infectious tubercular patients or patients suffering from other infectious disease to live in overcrowded residential areas.

When the Gothenburg City Council considered a plan to convert a former general hospital which was in the vicinity of residential areas into a tuberculosis hospital, people living in the neighbourhood protested against the plan. In the letter which they wrote to the City Council, they chose a line of reasoning which was very similar to that used by the First City Physician and the Health Committee. For example, the residents invoked the ideas of 'soil' and 'seed'. Firstly, they pointed out that people's resistance to the infection would be weakened by the fear which they would feel in living near the "death house." Secondly, they argued that the risk of infection and continuous re-infection was already high in this overcrowded neighbourhood, and by accommodating infectious tubercular patients in the area, the Health Committee would aggravate the situation. Furthermore, the residents argued that a large number of children would be exposed to infection, since there were several schools and a play-ground nearby. These kind of open protests, together with the discrimination which many tubercular patients experienced, compelled the Public Health Departments time and again to revise their anti-tuberculosis schemes. The health authorities in both Birmingham and Gothenburg depended to a certain extent on public fears to solicit funds, but on the other hand public fears could also paralyze the campaign.

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The groups which have been discussed in this Chapter - middle-class women, working-class women and working-class men - had different strategies in which they contested the health authorities' views and impressed their views on other groups and on local policy-makers. Middle-class women created new innovative services, working-class women allied with other groups and linked their own demands to campaigns which had wide currency in society, and working-class (male) organizations sought to accomplish their goals in the context of the official political system. All these protests were fragmented and contradictory, as were the public health campaigns. For example, in criticizing the municipal anti-tuberculosis campaigns, many writers in both Birmingham and Gothenburg urged the health authorities to take a wider view of the problem, and in particular to tackle poverty and to improve people's living and


101 See, for example, BPRO, HC, minutes 22. 4. 1902 items 7383-4; GSH 1902:90; 'Renströmska fonden', Ny Tid 12. 10. 1903; GSA, HVN I, minutes 2. 4. 1930 item 62 and documents K and L.
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working conditions. On the other hand, the health authorities were urged to take measures which were coercive and discriminatory. The public often expected the health authorities to single the sick out for attention and to isolate them from the rest of society.
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"The cancer research establishment likes us to believe that a shortage of research funds is the primary problem. Ignorance, in this view, is the basic cause of cancer."

"The key to cancer control is therefore knowledge - the great scientific breakthrough to wash away our stupor. But we already know a lot about cancer... We know... that cancer is the product of bad habits, bad government, bad business, and perhaps even bad science."


Public health authorities who campaigned against infant mortality and tuberculosis in the early twentieth century faced a problem very much analogous to that confronting the present-day cancer agencies. They knew much about the causes of infant death and tuberculosis but were not always willing or able to use the information they had. An important reason why many scientific findings were ignored or rejected was that the practical policies to which these findings seemed to lead were incompatible with the broader political and social goals of municipal health campaigns. For example, studies which linked poverty with infant mortality suggested that the well-being of infants could not be secured without a redistribution of income between the well-to-do and the poor, between the childless and those with children, or between men and women. In most cases, these kind of redistributive measures found little favour with the policy-makers who exercised a significant influence over the formation of public health policies and, therefore, evidence of a correlation between economic deprivation and infant mortality was *not taken to be knowledge* but was treated as a controversial research finding.

Similarly, studies which linked defective housing with tuberculosis suggested that without radical housing reform death rates from tuberculosis would remain high. If the anti-tuberculosis campaign was to succeed, municipalities or other non-speculative agencies should intensify their efforts to provide decent housing for people who were most likely to become ill: the poor. However, building healthy homes for those in the most acute housing need was extremely difficult as long as the provision of municipal and co-operative housing was inextricably linked into free-market policies. Hence health authorities, who rarely challenged the economic principles on which municipal housing policies were built, had to choose their words carefully in

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1 Robert N. Proctor, *Cancer Wars: How Political Shapes What We Know and Don't Know About Cancer* (New York 1995), 270.
disscussing the housing-tuberculosis connection. On the one hand, they argued that improving the standard of housing was an indispensable tool in the struggle against tuberculosis, and on the other hand they warned that studies concerning the housing-tuberculosis connection should not be taken too literally. The connection between defective housing and tuberculosis, they argued, was extremely complicated and, in consequence, housing reform was not the most efficient way of combating the disease. In discussing the housing-tuberculosis connection or the poverty-infant mortality connection, health authorities ended up manufacturing ignorance to justify non-action, instead of producing and using knowledge to take action. It was premature to draw conclusions, far too early to take measures.

While public health authorities had much information which they were reluctant to translate into practical policy, they always seemed to lack the kind of information which they would have liked to utilize. Public health experts and executives naturally enough had preconceptions about urban health problems and about appropriate responses to them. More often than not, they favoured strategies which encouraged the efficient working of the local economy and buttressed important social institutions such as the family. Furthermore, they tended to choose measures which were inexpensive and could be welded on to existing services. For example in Sweden, where emphasis had traditionally been placed on medical care, the interest was often in information which could spin off in the direction of new therapies, whereas in Britain public health authorities were more interested in information which could be useful in educational health campaigns. However, as this study of the Gothenburg and Birmingham health campaigns shows, it was not always easy to find strong scientific evidence to legitimate the policy which health authorities were determined to pursue. These cases reveal how creative health authorities were in constructing and reconstructing scientific knowledge to suit their purposes.

Unruly urban life and neat scientific categories

The knowledge on which public health policies in Birmingham and Gothenburg were based was partly 'produced' by public health officials themselves. In both cities, the health officials collected, edited and analyzed information about the incidence of diseases among different sections of the population and about the links between particular ways of life and the exposure to disease and death. Since the health officials used sanctioned scientific methods such as statistical techniques, the information which they produced was usually taken to be value-free and objective knowledge. However, by comparing the reports written by the Birmingham and Gothenburg health officials, it is easy to show that the knowledge of urban health problems was clearly structured by questions which the health officials asked and their questions, in turn, were shaped by their values and concerns and by policy legacies.

In charts, tables and maps which the Birmingham health authorities produced to analyze and illustrate urban health problems, the city was usually divided into "unhealthy", "less unhealthy" and "healthy" areas. In the unhealthy areas, where death rates were high, a large proportion of the inhabitants lived in old deteriorating...
houses in insanitary environment. Furthermore, the health authorities argued that in these areas people's attitudes and their patterns of behaviour - their social contacts, their diet and the ways in which they looked after their own body, their children and their home - were exceptionally irrational and unhealthy. The healthy areas consisted of middle-class suburbs, and between the salubrious suburbs and insanitary slums were the less unhealthy areas which were inhabited by lower middle-class and 'respectable' working-class families. In Gothenburg, in contrast, the health authorities did not define "unhealthy areas" but pinpointed problems on the map and in the community. Instead of concentrating on insanitary areas, the Gothenburg authorities paid their attention to low-quality houses which were scattered in the socially mixed city centre and in working-class areas. Instead of targeting 'problem areas' where people's attitudes and values were considered to be irrational and unhealthy, they concentrated on 'problem families.'

In arranging unruly urban life into neat categories, the health officials defined the frameworks of social action and therefore inevitably influenced the development of their city. In Birmingham, by defining the central wards as "unhealthy areas," the health authorities justified municipal intervention in all homes in these poor districts. Sanitary inspectors and health visitors were sent to inspect the houses and instruct the housewives in domestic hygiene. This system whereby some parts of the city were labelled and treated as problem areas was self-reinforcing. As the unhealthy areas gained an increasingly residualised status, the incentive for 'respectable' working-class people to move out became greater. The approach which the Gothenburg authorities chose furthered social segregation in the city in a subtler way, but on the other hand its effect on the every-day life of the 'problem families' was profound. For example, instead of introducing a health visiting system to instruct thousands of poor mothers in domestic hygiene, the Gothenburg authorities employed household advisors who visited about 100-150 'problem families' a year, spending in average four days in each family. In their efforts to put the problem families' life in order, the Gothenburg authorities subjected these families to close supervision and often allowed welfare calculations to override the wishes of family members.

Choosing the 'right' results

In utilizing the findings of medicine and the natural and social sciences, public health authorities were usually able to make choices. Scientists never spoke with a single voice on topical issues such as infant mortality and tuberculosis, and therefore health authorities could use scientific results that supported, at least to an extent, their preconceptions about the problems. The way in which the Birmingham and Gothenburg health authorities linked dysfunctional families with the problem of infant mortality illustrates the point. In Birmingham, the functional family consisted of husbands who were reliable breadwinners and wives who were both loving mothers and efficient managers of the home. Scientific findings which suggested that infant welfare could be secured by buttressing this particular family model were taken to be knowledge. The Birmingham health authorities knew that married women's industrial employment was an important contributing factor to infant deaths. They knew that in homes where mothers did not look after the
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household cleanliness, infants came inevitably into contact with "fatal" dirt. Furthermore, they knew that in poverty-stricken families where husbands spent a large proportion of their income on drink and where mothers' household management skills were poor, infants had a great risk of dying. The central aim of the Birmingham infant welfare campaign was to instil a sense of responsibility in these "ignorant and careless" husbands and wives and to secure as great a compliance as possible with the family ideal. Indeed the Birmingham campaign was committed to 'the family', sometimes at the expense of the child and the mother within it. In consequence, the Birmingham campaign was likely to be of benefit to mothers and children whose familial situation was in keeping with the normative roles, while it clearly placed an additional burden on mothers who were unmarried, who worked outside the home or who transgressed the maternal norm in some other way.

In Gothenburg, infant welfare was not as closely linked to the performance of particular gender roles as in Birmingham. The health authorities were clearly less concerned with the appropriate roles of husbands and wives in the family and more with the responsibilities of parents. In Gothenburg, the functional family consisted of parents who provided for their children and who protected their children's interests. Scientific findings which suggested that infant welfare could be secured by encouraging, or if need be, by forcing parents to be more responsible for maintaining their children were taken to be knowledge. The Gothenburg authorities knew that parents who evaded this responsibility were largely to blame for the high rates of infant mortality. They knew that illegitimate babies whose fathers did not pay child-support often suffered acute deprivation. They knew that in poor families where mothers were not able or willing to combine reproductive and productive activities, children were exposed to disease and death. Furthermore, the authorities knew that mothers' industrial employment and extra-familial child-care - nurseries and foster homes - were not necessarily inimical to infant welfare. At best the Gothenburg campaign helped poor working-class mothers cope with their immediate problems, but it also provided the authorities with means of controlling these mothers. In particular, unmarried mothers were subjected to demeaning supervision in order to 'protect' the interest of their children.

In this particular case, differences between the policies were not necessarily due to the values of the health officials. It is likely that the Gothenburg authorities were as attached as their British counterparts to the middle-class family ideal. What explains the difference was that the Birmingham health authorities were able to reconcile two objectives in their infant welfare campaign: the family's responsibility for self-support and the male breadwinner family model. The Birmingham authorities were convinced that the overwhelming majority of working-class men could maintain their families, especially if they stopped drinking and gambling. Hence families could be self-supporting, although women stayed at home and concentrated on their roles as wives and mothers. Furthermore, both local businesses, which were not particularly concerned to employ skilled or semi-skilled female labour, and male trade unionists were committed to reinforcing the male-breadwinner family model. In Gothenburg, reconciling the two objectives was not possible. The health authorities were clearly aware, firstly, that many working-class men were not able to maintain their families and, secondly, that there were a large number of women, unmarried mothers and widows, who were solely
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responsible for their children. Had the health authorities perpetuated the gendered division of labour in society, they would have implicitly encouraged the poorest families to turn to poor law authorities for help. In order to keep poor families off public funds, the health authorities encouraged women to work outside the home. Furthermore, this policy served the interests of local industries, and in particular textile and food processing industries, which employed semi-skilled and skilled female workers.

Rival interpretations

When public health authorities used scientific findings in the process of policy formulation, they, wittingly or unwittingly, reconstructed the findings to suit their purposes. The comparison of the Birmingham and Gothenburg campaigns shows how different and yet equally logical conclusions health authorities could draw from the same medical 'facts' and theories. What aspects of medical theories the health authorities emphasized depended on how far down in the chain of causation they looked when they defined health problems. The Gothenburg authorities often stopped with micro-organisms or micro events within the human body. They argued that micro-organisms or micro events were the "real causes" of infant death and tuberculosis and, in consequence, medical doctors were to play the key role in the construction and implementation of public health policies. The campaigns against tuberculosis or infant mortality were, to a large extent, scientific battles against disease-causing microbes. Infectious tubercular patients were isolated from the rest of society, and children born to high risk tuberculous families were kept out of the way of tubercle bacilli by boarding them out in healthy foster-homes. In the 1920s and 1930s, the Gothenburg authorities were active in developing and testing the vaccine against tuberculosis. Similarly, in order to reduce death rates from infantile diarrhoea, the health authorities provided sterilized cow's milk for bottle-fed babies and hospital beds for babies who were suffering from the disease. By locating the cause of disease in micro-organisms or micro events within the body, the public health experts and executives extended professional opportunities in medicine; a measure which was important in a country where doctors were reliant on central and local governments for their posts and pensions.

In Birmingham, in contrast, the public health authorities were more interested in the relation between disease and unhealthy habits. Although they often utilized exactly the same medical theories as their Gothenburg counterparts, the Birmingham authorities emphasized that micro-organisms alone did not explain health problems such as tubercular diseases or infant mortality. Only a small proportion of people who had suffered tubercular infection developed full-blown tuberculosis, and only some of the babies who were raised on cow's milk died from infantile diarrhoea. Looked at from this perspective, the "real causes" of tuberculosis seemed to be unhealthy habits which weakened bodily resistance and which facilitated the proliferation and transmission of disease-causing microbes in the homes. The campaigns against tuberculosis and infant mortality were educational projects which aimed to instil in people a sense of responsibility and to instruct them in a healthy way of life. At best these kind of campaigns inspired and empowered citizens to preserve
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their own health. But on the other hand, by ignoring the unequal abilities of people to change their habits, they failed to deal with many problems confronting the poorest families.

By concentrating on disease-causing microbes or disease-causing unhealthy habits, the Gothenburg and Birmingham authorities took a stance that wider environmental or social factors were only secondary contributors to disease. This conclusion was 'politically' important, since municipal housing schemes in both Birmingham and Gothenburg failed to provide decent housing for the poorest, unhealthiest section of the population. In Birmingham the poorest people, among whom both tuberculosis mortality and infant mortality were high, lived in deteriorating back-to-back houses throughout the period reviewed here. The health authorities justified the non-interventionist policy by arguing that unhealthy habits, not defective housing, were making people sick. People needed to face up to the fact that, to a large extent, it is their own actions that put them at risk. In Gothenburg, the poorest section of the population still lived in overcrowded small flats in the 1930s. Public health experts and executives acknowledged that small houses and tuberculosis were a dangerous combination, but they alleviated the problem by removing infectious patients to hospitals, not by improving housing conditions.

Science and urban society

The case studies of infant welfare and anti-tuberculosis campaigns show clearly that public health experts and executives, in spite of their ambitious rhetoric and occasional attempts to examine health problems in a broader context, sought solutions to these problems within the existing structure of class, gender and age relations, overlooking social change as a possible policy option. Hence the health policy which they pursued often served precisely those vested interests it claimed not to be contaminated by and reproduced the same inequalities it professed to level out. Health reforms which were aimed at narrowing social class differentials did not tackle structural problems such as poverty but concentrated on mitigating the consequences of these problems. Hence the health authorities' attempts to level out inequalities in health often served to legitimate the disparity of wealth and power which, in turn, was an important underlying cause of disease and ill-health. Similarly, health reforms that were aimed at improving women's health did not attack women's inequality in the family or in the labour market; on the contrary, they usually encouraged women to accept these inequities as a part of natural order. Thus, while municipal health care services benefited women in

2 In early twentieth-century Sweden and Britain, the prevalence of absolute poverty and deprivation, which was partly due to the gross disparity in the distribution of wealth, contributed significantly to the high mortality and morbidity rates. However, not only absolute poverty but also relative poverty affected (and affects) health. Many writers have shown that even in affluent societies, where the vast majority of the population is above some basic level of subsistence, large income differences (= widespread relative poverty and relative deprivation) are an important contributory factor to ill-health. Richard Wilkinson, 'Health, redistribution and growth', in Andrew Glyn and David Milliband (eds), Paying for Inequality: The Economic Cost of Social Injustice (London 1994), 24-43; J. W. Lynch, G. A. Kaplan and J. T. Salonen, 'Why do poor people behave poorly? Variation in adult health behaviours and psychosocial characteristics by stages of the socioeconomic lifecourse', Social Science and Medicine 44 (1997), 809-19; Peter Townsend, Nick Davidson and Margaret Whitehead, 'Introduction to Inequalities in Health', Inequalities in Health: The Black Report & The Health Divide (London 1988), 1-27.
some respects, these services also went a long way towards confirming their status as second-class citizens which lay at the root of many health and social problems they experienced.\(^3\)

In addition to class, gender and age aspects, professional interests were identified as a necessary factor in analyzing the direction and form infant welfare and anti-tuberculosis campaigns took. Although the health authorities pledged themselves to act in "the best interest of the community", accommodating the interest of the medical profession often seemed to be a higher priority. Both leading health officials and decision-makers thought long and hard before they introduced any reforms that were expected to provoke widespread discontent in medical circles. Hence public health policy served to sustain existing hierarchical relations, firstly, within the medical profession, secondly, between medical doctors and other health care providers and thirdly, between medical doctors and their patients. Finally, public health campaigns were clearly successful in conveying an impression that medical doctors had superior knowledge not only about diseases and injuries but also about matters such as poverty, the role of family and the place of women which were closely connected to health issues.

The effectiveness of public health policy in shaping wider political and social processes was largely built on two generally accepted assumptions about science and society. The first assumption was that science told with increasing accuracy about the natural world, and often of humankind and society too. The second assumption was that society's welfare ultimately depended upon how well both individuals and society as a whole conformed to this accurate knowledge. As Dr. George Newman said, "(m)ore and more do we ally ourselves with Nature and, learning her secrets, her ways of doing things, endeavour to imitate her and work along the line of her laws. The wise physician is he who works not in opposition to her, but in co-operation with her."\(^4\) Science and scientific knowledge were seen as something autonomous, an entity that should and "could be trusted to shape society since its own shape was produced by truths external to ... society."\(^5\) Thus, as long as health authorities appeared to help society and individuals conform to scientific knowledge, it was widely assumed that health policy contributed to the well-being of society.

However, although the effect of public health policies on social relations was profound, it was always, to an extent, unpredictable and unexpected. In most cases, public health experts and executives sought to reinforce existing economic and social arrangements, but were not always able to predict accurately how people would respond to their policies. They sought to influence the development of the city, but did not always know whether their measures would further social segregation or integration. More often than not, early-twentieth


\(^5\) Hollinger, 'Free enterprise', the quote 902. See also, Good, *Medicine*, 3.
CONCLUSION

century measures which aimed to improve living conditions in the poorest areas actually furthered social segregation. Similarly, measures which sought to 'protect' a group of people, for example unmarried mothers and their children, could subject these people to demeaning supervision, while measures which were aimed at restricting the freedom of individuals could mean gains in liberality. Given this ambiguity, it is hardly surprising that public health authorities were often accused both of daring too little and of risking too much. What also complicates the issue is that health experts and executives often had different views on how to regulate social relations in cities. The leading health officials, the MOHs in Birmingham and the First City Physicians in Gothenburg, rarely suggested radical changes in municipal policies, but they were clearly aware of many different aspects of urban health problems and more critical of existing economic and social arrangements than the majority of public health executives. The critical attitude which these health officials had did not undermine their ability to buttress the existing social system; on the contrary, it probably made them well suited for the task.

"Social systems are never saved by true believers, the virtues appropriate to going down with the ship rarely being suitable for the arts of navigation."

Robert Skidelsky (1992)6

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